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UNIT MINISTRY TEAM RELIGIOUS SUPPORT TO CASUALTIES ON THE AIRLAND BATTLEFIELD

FINAL REPORT

DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES ARMY TRAINING AND DOCTRINE COMMAND
FORT MONROE, VIRGINIA 23651-5000

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NOTICES

DISCLAIMER

The findings in this study are not to be construed as an official Department of the Army position, unless so designated by other authorized documents.

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ACKNOWLEDGEMENT

U. S. Army Chaplain Center and School initiated and sponsored this study. Chaplains assigned to the Directorate of Combat Developments, Academy of Health Sciences, Fort Sam Houston, Texas, collected the data and analyzed it in consultation with the Study Advisory Group and a Subject Matter Expert Panel.

The Subject Matter Expert Panel included: Chaplain (COL) Irving Njus, Chaplain (LTC) Douglas Groen, Chaplain (LTC) Jim Berbiglia, Chaplain (LTC) Gerald Conner, Chaplain (MAJ) Robin Aplet, and Chaplain (MAJ) William Caple.

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Chaplain (LTC) David Williams began the study. Chaplain (LTC) Mark Gruebmeyer, Special Studies Branch, Concepts Division, Directorate of Combat Developments, Academy of Health Sciences, Fort Sam Houston, Texas, completed it.

The findings are the last writer's opinion and are not to be construed as official Chaplain branch doctrine nor as the official Department of the Army position.

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ABSTRACT

"Unit Ministry Team Religious Support to Casualties on the AirLand Battlefield" is a study of chaplains' and chaplain assistants' roles, functions, tasks, and capabilities in providing religious support to casualties on the AirLand battlefield.

The study was designed to define Unit Ministry Team ministry to casualties, assess Unit Ministry Team support in doctrine and training, determine the scope of Unit Ministry Team support requirements, identify Unit Ministry Team capabilities, evaluate the role and the function of the chaplain assistant in religious support to casualties, and identify changes required in doctrine, organization, operational concepts, and training to correct deficiencies.

Findings are based upon an extensive search of civilian and military literature which references religious support provided to casualties, upon responses to questionaires sent to division chaplains and chaplains assigned to hospitals in Vietnam, and upon insights provided by a Subject Matter Expert Panel.

Analysis identified five spiritual conditions which Unit Ministry Teams address in eight different, yet overlapping and interrelated, ministries. The spiritual conditions are: crisis of faith, fear, grief, guilt, and despair. The ministries are: ministry of presence, ministry to the dying, crisis and stress ministry, sacramental ministry, ministry of sustaining, ministry of guiding, ministry of worship, and ministry of celebration.

Deficiencies include: lack of capabilities to locate and move to casualty treatment locations, inadequate abilities to provide coordinated ministry in mass casualty situations, inadequate ability to function in contaminated environments, lack of manpower requirement criteria for assigning Unit Ministry Teams to medical treatment facilities, and inadequate ability to provide distinctive religious group ministrations.

The study notes how neither chaplain branch nor health service support doctrine adequately describes Unit Ministry Team religious support to casualties.

The study recommends changes in doctrine, training, organization, and policy to correct these deficiencies. It also recommends separate studies to correct deficiencies in providing religious support in contaminated environments and in providing distinctive faith group ministrations.

The study emphasizes spiritual, theological, ethical, and psychological preparedness for combat ministry to casualties as essential to providing adequate religious support to casualties on the AirLand battlefield.

CHAPTER I

INTRODUCTION

The purpose of this study is to assess and analyze religious support to casualties on the AirLand battlefield. Assessment helps establish requirements for religious coverage and determine manpower standards and criteria. Analysis helps chaplain branch combat developers to identify deficiencies in doctrine, force structure, and training. Analysis also aids chaplain branch proponents in describing essential religious support to others.

Neither chaplain nor health service support doctrine clearly describes the Unit Ministry Team's (UMT) role, function, tasks, nor capabilities in providing essential religious support to casualties. This deficiency contributes to other branches not understanding UMT contributions to individual and unit effectiveness, unit cohesion, esprit, moral and spiritual fitness, and morale.

Failure to describe UMT capabilities in supporting healing, stabilization, and stress reduction, results in military commanders and medical treatment personnel not understanding UMT contributions to caring for casualties and returning them to duty.

Failure to establish standards and criteria for manpower requirements results in a misaligned UMT force structure to support the combat mission.

Not clearly identifying deficiencies prevents development of the best possible corrective solutions in doctrine, training, force structure, and policy.

In a letter dated 25 March 1985 to the Commander, U. S. Army Academy of Health Sciences, Chaplain (LTC) Donald Gover, Chief, Course Development, U. S. Army Chaplain Center and School (USACHCS), wrote "In reality, we do not have established doctrine for highly specific instruction on either medical or battle shock/stress casualties and, as a result, have not developed instruction in support of these issues." Thus, highly specific training "is extremely limited."

USACHCS published "Battle Fatigue Ministry" (FC 16-51, September, 1986) to address this deficiency. They are presently developing instruction in ministry to battle shock/stress casualties. They have not further developed either doctrine nor instruction on how to minister to other medical casualties.

In reply to a request for information on current Army Medical Department doctrine and training on chaplain support to casualties in the health care system, Lieutenant Colonel Laurence Christman, Chief, Doctrine and Training Literature Division, U. S. Army Academy of Health Sciences, wrote on 24 January 1985, "...there is no current doctrine and training for chaplain support."

To address these deficiencies, the Director of Combat Developments (DCD), Academy of Health Sciences (AHS), directed Chaplain (LTC) David Williams, assigned to Concepts Division, DCD-AHS, on December 3, 1984, to begin the TRADOC 5-5 study entitled "Chaplain Support to Casualties on the AirLand Battlefield."

Frequent changes in emerging doctrine frustrated the study's timely completion. For an example, changing from a single stream to a two stream and now possibly back to a single stream medical evacuation system changes religious support requirements.

According to the TRADOC AR 5-5 Study Plan, ACN 064346, dated 3 December 1984, the objectives of the study are:

1) To assess the problem systematically in order to draw objective analytical conclusions on chaplain support to casualties.
2) To assess chaplain support in doctrine and training by the proponent branch and in current and emerging medical doctrine.
3) To assess the role and the function of chaplain support to the casualty.
4) To determine the scope of chaplain support requirements for the broad spectrum of casualty care from the point of wounding to hospitalization.
5) To identify and prioritize chaplain capabilities for casualty support.
6) To assess the chaplain support requirements to TOE casualty care units without organic, internal chaplain capabilities.
7) To identify religious issues being asked by chaplains and commanders confronted with the AirLand environment, congruent with the reality of the integrated battlefield, as these issues impact upon casualty care.
8) To evaluate role and function of the chaplain assistant as a member of the Unit Ministry Team in the pastoral care of casualties, e.g. support to "Battle Stress" casualties.
9) To identify changes in doctrine, organization, operational concepts (O & O), and in training to overcome deficiencies.

Two related TRADOC 5-5 studies are:

"Chaplain Support to the Maneuver Battalion," ACN 044666, an uncompleted study which provided some useful data reference commanders' expectations.

"Battlefield Religious Coverage," ACN 036882, which is a competed study.

According to the TRADOC AR 5-5 Study Plan, this study assumes the following:

1) Forward Thrust doctrine will be implemented in the 1990's in the L TOE series.

2) The individual soldier has religious needs over and above denominational requirements.

3) Pastoral care by chaplains to casualties has a positive effect upon the wellness of and rapid return to duty of casualties.

4) The presence of the chaplain with the casualty is a morale multiplier for the unit in combat.

5) The chaplain is a "combat" person, in the same manner as the medic.

6) The chaplain is a member of the medical team providing health care. A spiritual model for ministry to casualties is subsumed as integral to a medical model for healing.

7) The chaplain is a role model and father figure to soldiers in demonstrating positive approaches in dealing with pain, suffering, grief, and death.

8) It is assumed that questions/issues raised in Objective 7 may be better addressed in a separate study.

Other assumptions made during the course of the study include:

1) Recent theological and pastoral care literature provides data and insights useful in developing operational concepts for UMT ministry to casualties.

2) Related psychological and sociological literature provides complementary data and insights.

3) Articles by and interviews with combat veterans who served in World War II, Korea, Vietnam, and Grenada provide insights concerning requirements for ministry in future conflicts.

4) Responses to questionaires, although subjective, provide useful data.

5) Basic AirLand battle and health service support doctrine will not change, although how health service support is organized for combat may change in the near future.

6) Soldiers' and commanders' expectations of chaplain support to casualties have not changed in the last forty years.

7) Force structure in future conflicts will be extremely austere.

8) Using a subject matter expert panel is an acceptable way of establishing manpower requirements.

9) Total Army Analysis 93 (TAA 93) casualty projections are adequate for planning future requirements.

10) Providing religious support to casualties is an integral part of providing religious support to all soldiers, including noncasualties.

11) The spiritual health of soldiers is as important as the their physical health or the condition of their equipment in sustaining combat operations.

The intelligence used for this study correlates with that used in the development of Total Army Analysis 93 (TAA 93).

CHAPTER II

THREAT FACTORS

Factors on the AirLand battlefield include:

- Highly lethal weapon systems
- Intense around the clock combat lasting several days
- Broad ill-defined fronts
- Massive concentrations of forces and fires
- Attacks upon every echelon simultaneously
- Formidable enemy air power
- High risk movements at every level
- High probability of NBC early in the battle
- Electronic warfare
- Directed energy warfare
- Unconventional warfare
- Lack of secure areas for rest and recuperation (R & R)

The threat varies according to the intensity of the conflict. Broad frontages, deep targets, and enemy penetrations of varying depths characterize the mid-high intensity European scenario used in this study.

Any event or contingency that reduces combat, combat support, or combat service support effectiveness by producing medical casualties is a medical threat.

Casualties are any persons who are lost to their organization by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing in action, beleaguered, besieged, or detained. (NATO definition)

Medical casualties are those who receive medical treatment within the health service support system, namely wounded, injured, diseased, retained, or beleaguered soldiers.

The study's scope limits threat considerations to the medical threat to soldiers in echelons at corps and below within a European theater from the point of wounding through the theater health service support system. The scope further limits analysis of religious support to casualties to that provided to medical casualties.

Mid-high intensity conflicts generate a higher percentage of certain types of casualties than do light intensity conflicts. These include a higher incidence of deaths, mass casualties, and battle fatigue casualties.

Mid-high intensity conflicts also produce more mission degradation due to protective postures, equipment damage, and disruptions in evacuation,

communication, and resupply. Contamination of unit personnel, equipment, and supplies is an added threat factor in NBC environments.

In mid-high intensity conflicts or mass casualty situations, medical casualties may far exceed medical capabilities. Surgical capabilities, evacuation resources, and bed capacities may be insufficient.

Computer simulation models and past combat experiences suggest that the killed in action to wounded in action ratio may be as high as one to five. According to TAA 93, approximately one in four casualties may suffer multiple fragment wounds. More than half of all wounds may hemorrhage. Approximately 75% of all casualties may require some form of surgery.

Ground and air ambulance squads, combat medics, and forward deployed medical treatment teams are vulnerable to enemy armored combat vehicles, massive artillery barrages, air attacks, and enemy breakthroughs, particularly during daytime movements and evacuations. They may become isolated as battlelines remain ill-defined or the FLOT changes during tactical withdrawals.

Total Army Analysis 93 does not project casualties within an NBC scenario. Nuclear warfare generates a higher incidence of burns, eye injuries, and hearing loss in addition to radiation injuries. Chemical warfare generates psychological, neurological, and nonspecific symptoms in addition to chemical contamination and injuries. Biological warfare generates casualties infectious to others, in addition to causing biological diseases.

NBC warfare produces combat stress related to the uncertainty of the amount or type of exposure, uncertainty of the completeness of decontamination, and the delayed effects of some NBC agents. Psychophysiological symptoms of heat stress, fatigue, and antidote reactions, due to excessive use of atrophine in relation to exposure, increase combat stress.

NBC warfare may produce mass casualties which far exceed medical capabilities. Deficiencies may include insufficient medical treatment personnel, medicines, antidotes, and decontamination or evacuation resources to provide essential medical treatment.

Treating casualties in a contaminated environment in MOPP IV is extremely difficult, if not impossible. Evacuating contaminated casualties, decontaminating casualties and equipment used to transport them, and maintaining "clean" environments is time-consuming, resource depleting, and difficult.

High intensity conflicts produce battle fatigue casualties in direct proportion to the intensity, lethality, and duration of the battle. Current Union of Soviet Socialist Republics (USSR) doctrine emphasizes producing "battle paralysis" using combined arms, massive attacks upon all echelons simultaneously, continuous operations, and unconventional warfare.

Other combat stress factors include:

- sleep loss
- exhaustion
- risks of being wounded by "friendly fire"
- unit attrition
- first time combat for junior soldiers and leaders
- degraded communications
- isolation
- reduced resources for rest,hydration, nutrition, personal hygiene, and recuperation
- unit leadership

In past wars, the ratio of combat stress casualties to physically wounded casualties has been approximately one to three or four. In some cases, the ratio has been as high as one to one.

Unit Ministry Teams will be hard pressed to provide religious support during the battle phase of AirLand battles to both casualties and noncasualties. All soldiers on the battlefield require religious support, not just casualties. Priorities for religious support will vary as soldiers needs, unit missions, and battlefield scenarios vary.

General threat implications for UMT religious support to casualties include:

- difficulty in locating casualties due to their dispersion and/or impaired communications
- difficulty in moving to casualty treatment locations without UMTs becoming casualties themselves
- difficulty in providing religious coverage for all the many casualty collection points, treatment locations, holding areas, and ambulance exchange points within the UMTs area of operations
- difficulty in providing required religious support in mass casualty situations
- difficulty in providing religious support to unconscious and disoriented casualties
- difficulty in providing religious support in an NBC environment in MOPP IV
- difficulty in coping personally over an extended period with all the trauma, horror, and stresses of the integrated battlefield without UMTs suffering combat stress reactions themselves

Unit Ministry Teams can lessen their risks of becoming casualties by:

- limiting independent daytime movements
- restricting lateral movements on the battlefield
- when possible, moving with units and soldiers in convoys
- moving at night using night vision devices
- being proficient in common soldier skills, such as cover and concealment, land navigation, communication, escape and evasion, and NBC survival

- applying tactical considerations in all actions
- understanding the battlefield in all its complexities
- knowing the unit's tactics and mission in all its phases
- training with soldiers and their units
- maintaining mental and physical fitness, emotional health, and a clear spiritual focus grounded in commitment to God and others in faith, hope and love

CHAPTER III

REQUIREMENTS FOR RELIGIOUS SUPPORT TO CASUALTIES

The First Amendment of the Constitution guarantees to all soldiers the right to free exercise of religion. Only the needs of the combat environment and the unit's military mission limit this right.

Military regulations recognize requirements for religious support. Regulations assign primary staff responsibility for assisting the commander in addressing these requirements to the staff chaplain.

According to military regulation (AR 165-20, Chapter 3, para 3-1, 10 May 1985):

> a. Commanders are responsible for the religious, spiritual, moral, and ethical well-being of all personnel in their commands. They will give necessary support to ensure that these requirements are addressed. (See AR 210-10, paras 2-1 and 6-1). The staff chaplain has primary staff responsibility to assist the command in the planning, development, and implementation of these command responsibilities.
>
> b. Commanders should be aware of, and sensitive to, special religious requirements of personnel within their command. Commanders should accomodate religious requirements of personnel when consistent with law, regulations, and the military mission.

Special religious requirements include:

- Viaticum, which Roman Catholics are "bound" to receive when death is close[1]
- Baptism, which many Christians confess as important to eternal salvation
- Holy Communion, usually administered by ordained ministers, which is essential in many religious groups to receiving God's forgiveness
- Anointing of the Sick, by which Roman Catholics receive the "grace of the Holy Spirit" by which "the whole person is helped and saved, sustained by trust in God, and strengthened against the temptations of the Evil One and against anxiety over death."[2]
- Sacrament of Holy Unction, through which Eastern Orthodox believers receive healing of the body and the soul and the forgiveness of sins
- Absolution of the Dying, a requirement for Eastern Orthodox believers
- Deathbed confession, which Jewish tradition views as important to the transition to the world to come.[3]

Almost all religious groups consider religious support by chaplains representing God and religious communities of faith as essential, especially for casualties who are dying. Ministry facilitates peace with God and others, easing the transition from life through death.

Many religious groups believe, teach, and confess that prayers, anointing with oil, laying on of hands, and the sacraments are essential to healing and rapid recovery from wounds, injuries, and diseases.

Soldiers expect chaplains to be with them in battle to pray with and for them, to provide care and consolation if they are wounded, and to minister to their religious needs. Historically, in every conflict fought by American soldiers for over two hundred years, chaplains have provided ministry to soldiers on the battlefield.

Military commanders recognize the importance of chaplains' contributions. General Dwight D. Eisenhower wrote in 1946, "A good chaplain in the Army is worth more than his weight in gold."[4] General Brehon Somervell, Commander of Services of Supply under whom the chaplains served, said in 1951, "Living and working with the troops, the chaplains furnished one of the greatest morale factors in the war. Before battle and during it, the soldier could always turn to the chaplain for strength, and courage...."[5]

Senior commanders have stressed the importance of moral creeds and spiritual health in sustaining soldiers in battle. General Omar Bradley wrote in 1949, "For without the essential strengthening of our basic moral creeds, we can never hope to achieve our goal."[6]

General George C. Marshall wrote:

> ...I look upon the spiritual life of the soldier as even more important than his physical equipment...The soldier's heart, the soldier's spirit, the soldier's soul are everything. Unless the soldier's soul sustains him, he cannot be relied upon and will fail himself and his commander and his country in the end.
>
> It's morale--and I mean spiritual morale--which wins the victory in the ultimate, and that type of morale can only come out of the religious nature of a soldier who knows God and who had the spirit of religious fervor in his soul.[7]

In 1985, General John Vessey said, "The spiritual health of the Armed Forces is as important as the physical health of its members or the condition of the equipment."[8]

National leaders share commitment to providing for the religious needs of soldiers. President Franklin D. Roosevelt once said, "...we will never fail to provide for the spiritual needs of our officers and men under the chaplains of our armed services."[9]

Chaplains and chaplain assistants support military readiness by encouraging and supporting moral and spiritual fitness, ethical and spiritual values, spiritual morale, and the religious nature of soldiers. They commit themselves to providing for soldiers' religious needs by meeting religious requirements.

Requirements for ministry are the greatest during times of great stress, trauma, and uncertainty. The modern integrated battlefield will produce unparalleled trauma and stress. Contributing factors include: the lethality of modern weapons and massive attacks and fires.

Soldiers will lose lives, limbs, and buddies. If soldiers become casualties themselves, they may experience the uncertainty of recovery and the pain of traumatic injuries. Many may experience horror and brutalization.

As many as one out of five casualties may die on the battlefield prior to being admitted to a medical treatment facility. As many as one out of three casualties may be a battle fatigue casualty requiring some form of crisis intervention.

Total Army Analysis 93 projects that one out of four casualties admitted to Echelon III medical facilities may have multiple fragment wounds. Approximately 6.5% may lose limbs, 3.7% may suffer burns, and 74.8% may require surgery to treat their wounds or injuries. Approximately 18% may have life-threatening conditions, and 18.1% may have permanent disabilities.[10]

The roles, functions, and tasks of the Unit Ministry Teams in their ministry to casualties vary as the number of casualties and the mix of casualty categories vary. Highly intense and long battles and/or the enemy using NBC weapons generate more combat stress reaction casualties. Terrain, weather, and environment affect the number and mix of disease and non-battle injury casualties.

The casualties who require the most ministry are:

- those who are dying, or triaged as expected to die
- those diagnosed as having life-threatening conditions
- those who have suffered losses of limbs or other losses
- those suffering high levels of pain
- those suffering battle fatigue
- those returning to duty following treatment

The dying require religious support which addresses their fears, losses, guilt, grief, and despair, in order to ease the transition from life through death.

The dying fear the unknown. They fear loneliness and abandonment in dying. They fear losses of consciousness, courage, and dignity. They wonder what will happen to their bodies and spirits after they die. They wonder what will happen to their families and friends.[11]

When the dying who are afraid do not receive religious support which addresses these fears, they may become even more fearful. They feel that no one, including God, cares enough to be with them. They have no trusted external religious resource to counter unrealistic fears. They have no spiritual reassurance that their wants and desires in dying will be fulfilled.

Unit Ministry Teams are specifically trained to provide religious support to the dying which addresses their fears from a religious perspective. UMTs offer spiritual resources which are related to ultimate realities.

This religious support is more than emotional or psychological support. When other resources fail, religion offers hope in the midst of fear beyond that which is humanly knowable. Religion offers faith that is "the assurance of things hoped for, the conviction of things not seen" (Hebrews 11:1). It offers divine love. It offers hope beyond earthly hope.

The dying require religious support which assists them in their grief. Many grieve by anticipating losses. They require trusted assurances that families and friends will receive help, that that they will not be abandoned, and that they will receive pain medications.[12]

As the dying bargain with God to get well, desire miracles, become angry about dying, and become depressed, they require religious support which facilitates catharsis.[13] Some religions offer the assurance that even "to die is gain" (Philippians 1:21).

When the grieving do not receive this religious support, they lack a resource that may enable them to reframe their experiences of loss into contexts of meaning that facilitate acceptance. They may suffer a prolonged agony in dying. They may die troubled and cut off from death-accepting attitudes which help ease the transition from life through death.

The dying require ministry designed to alleviate any guilt they may be experiencing. Many will want to confess their sins and receive absolution prior to their deaths. Some believe this to be important to eternal salvation. They want to "make peace with God" and others.[14]

When the dying do not receive this religious support, they cannot freely exercise one of the more important aspects of their religion. The deathbed confessional is important in Jewish as well as Christian traditions. It begins the process in which the dying receive what is proclaimed as divine forgiveness. Many religious groups teach that divine acceptance is essential to eternal salvation.

In many religious groups, ordained ministers or priests have authority to facilitate this process of forgiveness that others do not have. Roman Catholic, Eastern Orthodox, Episcopalian, and Lutheran churches are among the many that teach that ordained ministers or priests have special authority to forgive sins.

The dying who are in despair require ministry which encourages them to take leaps of faith.[15] UMTs encourage faith and hope that God cares, is present, and does not forsake either the dying nor soldiers on the battlefield. Many religious groups teach that death can be transcended and have a meaning beyond itself. Many teach that there is life beyond the grave.

Not providing this religious support deprives soldiers of resources which facilitate hope within the midst of despair. They die troubled without the support of the resources of religious communities. They die not at peace with God, with others, and often themselves.

Preparing all soldiers to face death with courage and hope is one of the most important ministries that Unit Ministry Teams provide. This preparation sustains soldiers in battle and supports courage in the midst of battle.

Some casualties require religious support which is sustaining and helps them transcend circumstances in the direction of healing and hope.[16] These include casualties who have suffered losses of limbs, received neurological injuries resulting in paralysis, received disfiguring or mutilating wounds, have major organ damage, who are permanently disabled, and/or whose conditions will not ever change or at least not very much in the near future. They require assistance to find the courage to confront and live with their disabilities.

When these wounded casualties do not receive this religious support, they often become deeply depressed. They see no hope beyond and may even be suicidal. They may suffer overwhelming despair. They may refuse to cooperate with medical treatment personnel. They may frustrate rehabilitation. They may not develop their potentials. They may become withdrawn and uncommunicative.

UMTs affirm religious resources as important to overcoming disabilities and/or learning to live with them. They affirm wounded soldiers in their present state as valuable human beings. They encourage soldiers to enlist divine help in developing remaining potentials. Extensive religious literature supports the value of religious resources in this process.

Battle fatigue casualties require religious support which reduces stress, reinforces coping resources, and aids soldiers in integrating their combat experiences into frameworks of meaning that facilitate acceptance.[17] Some require supporting sacraments. Most require opportunities for catharsis, or telling their story until it is purged of its horror.

Psychically numb, emotionally anesthetized, or ethically immunized casualties require religious support which sensitizes them to the needs of others. They require opportunities for resolving related grief and guilt. They often require help to develop belief systems, world views, and faith which will support them in coping with battlefield trauma.

Depriving soldiers of this religious support deprives them of resources which support courage in battle and facilitates acceptance of battlefield trauma and chaos. Teaching crisis management and stress reduction techniques decreases the likelihood that soldiers will be overwhelmed by the brutalization

of the battlefield or become battle fatigue casualties. Or at least the effect of the brutalization will be less.

Casualties who have received treatment and are returning to duty require more than simplistic reassurances that they will survive or not be wounded again, as this cannot be known. Many require combat stress ministry. They may also require assistance in resolving moral and ethical dilemmas as they experienced them in combat.[18]

Not providing this religious support deprives soldiers of resources which can support them in battle to perform courageously and ethically.

Prayers, Holy Communion, religious services, special sacraments, baptism, comfort, reassuring counseling, religious literature, the chaplain's presence, spiritual direction, anointing, and empathy were some of the most requested religious acts that chaplains provided to soldiers in surgical, field, and evacuation hospitals in Vietnam.[19]

Not providing this religious support limits soldiers' free exercise of religion. It also deprives them of important supportive religious resources which can aid their healing, stabilization, stress management, rapid recovery, and return to duty.

Religious support requirements include those of medical treatment personnel caring for casualties. Combat medics suffer one of the highest rates of death and becoming wounded of all military specialties. All echelons on the battlefield and medical treatment units are subject to attack.

Working conditions may be less than ideal. J. Wilson, a combat nurse in Vietnam, described the work as filled with "unrelenting experiences of constant casualties, mangled bodies, 24-hour shifts, God-like medical decisions about treatment, and a daily experience of the death of young boys."[20]

Traumatic events, as experienced in caring for casualties, disrupt basic assumptions about personal safety, self-image, and the meaning of one's world.[21] Many struggle to find meaning in their experiences.

Barbara Rogers and Janet Nickolaus write, referring to their experience in Vietnam, "Fatigued by the work and overwhelmed by the emotional impact of events, many were unable to integrate their experiences and maintain psychological equilibrium."[22]

Some medical personnel in Vietnam reported losing confidence in and or becoming suspicious of authority figures.[23] Some discovered that the sheer horror of their experience eroded much of their initial sense of mission.[24] Some became disappointed and felt betrayed by the ideals and values which sent them into combat.[25] Some felt that God had abandoned them.[26]

Self-concepts changed. Medical personnel who were socialized to save lives and treat wounds discovered feelings of wanting to kill or hurt others, namely the enemy.[27]

Many medics grieved the deaths of those for whom they cared.[28] Some felt guilty about not having known enough, done enough, or being efficient enough to overcome all adversities, save all lives, and even perform superhuman deeds.[29] Many felt like failures, assuming extraordinary responsibility for those for whom they cared.[30] Many felt guilty.[31]

Requirements for religious support to medical treatment personnel thus includes ministries which address fears, grief, guilt, and despair. Medical treatment personnel require opportunities for catharsis and the sharing of thoughts and feelings. They require reassurance that life has meaning. They require assurances of God's forgiveness, understanding, and acceptance.

Some staff require guidance as they struggle with their own values, theological world-views, and moral and ethical behavior. Those assuming extraordinary responsibility need confronting. Also required are services of worship, sacraments, times for reflection and study, and opportunities for supportive fellowship within a religious context.

The ministries that chaplains most provided to medical treatment personnel in Vietnam in surgical, evacuation, and field hospitals were reassurance, leading informal support groups, listening, pastoral counseling, religious services, Bible studies, drug abuse counseling, sharing the concerns of staff, confronting immoral behavior, and spending time with staff.

Not providing this religious support to soldier medics deprives them of spiritual resources which may aid their caring for casualties. Religious support decreases the likelihood that medical staffs will become demoralized. It supports ethical behavior and encourages sensitive caring for casualties' needs. Religious resources offer hope beyond what's seen. Thus it can enhearten medical personnel when they are most disheartened.

CHAPTER IV

SPIRITUAL CONDITIONS

For the purposes of this study, a spiritual condition is defined as an ailment of a person's spirit that is related to ultimate realities and meanings. It involves a religious perspective and is profoundly religious in both context and content. A person best resolves a spiritual condition using religious resources.

Casualties experience five different interrelated spiritual conditions to which Unit Ministry Teams respond. They are: crisis of faith, fear, grief, guilt, and despair.

These conditions are spiritual when soldiers ascribe ultimacy to them, relate them to faith relationships with God and communities of faith, make them the subject of theological inquiry, conceptualize them theologically using "God" language, and use religious and/or spiritual resources to resolve them.

UMTs are uniquely qualified to provide religious support to casualties suffering from these conditions. Others, including psychiatrists, psychologists, and social workers, treat similar conditions. But others do not treat these conditions as spiritual conditions. Nor do they offer specifically religious resources. This is not their function. It is the UMT's function on the battlefield to provide support that is religious in both form and content.

Casualties may suffer from one or more of these spiritual conditions. Each of these conditions can be limiting or disabling. Each may slow or frustrate healing, stabilization, stress reduction, or casualties rapidly returning to duty following treatment.

CRISIS OF FAITH

A crisis of faith is a loss of confidence in a center of meaning or value. A casualty may lose confidence in military values and purposes, leadership, the medical system, friends, family, self, life's purpose, meaning, and value, and/or ultimately God.

A casualty may question why a loving, just, and omnipotent God permits the suffering and sacrifices of war. The philosopher Epicurus (341-270 B.C.) first articulated this dilemma. Leibnitz further described it in a book entitled Theodicee in 1710.

If God is, and if God is both able and willing to alleviate human suffering, why doesn't God do it now? If God is able to alleviate suffering, and is unwilling to do so, God is both uncaring and unjust. If God is unable to alleviate suffering, but willing, God is impotent. If God is both unable

and unwilling to alleviate suffering, God is existentially removed from the plight of those who are suffering. Each option offends traditional beliefs concerning God, hence the dilemma.[1]

A casualty may experience a crisis of faith in relation to any center of meaning, value, or power. For an example, the center of meaning, value, or power may be the medical system. If the medical system is so able and so willing to alleviate suffering, then why does it not alleviate suffering now? If suffering is not alleviated, the system is uncaring, unjust, unwilling, impotent, or existentially removed. This is a crisis of faith.

The theodicy dilemma can be resolved through reassuring the casualty of the center of meaning or value's omnipotence, care, justice, and/or willingness to alleviate suffering. However, when reassurance is not sufficient and the dilemma persists, the one in crisis may require religious resources to resolve the crisis.[2]

Casualties may resolve the crisis of faith religiously in many different ways. They may resolve the crisis by accepting suffering as God's will and/or plan. Or they may perceive that redemption comes through suffering. Some may interpret suffering as the result of an ultimate apocalyptic conflict. Others may continue to have faith in the center in spite of the suffering. Some may simply believe in waiting patiently for a redemptive resolution. Each resolution may ease the crisis.

Unit Ministry Teams assist casualties to resolve this dilemma and regain confidence in God and other centers of value and meaning through listening, sharing reflections, praying together, and sharing the suffering.

UMTs provide reassurance by their presence and witness that God is indeed caring, just, and powerful to act, at times even miraculously. They affirm and support chosen religious resolutions and offer others as possibilities. How those in crisis resolve this dilemma depends upon their faith perspective and the religious resources available to them.

UMTs also assist those experiencing crises of faith to develop theological world-views that afford meaning to the suffering, trauma, inhumaneness, irrationality, and brutalization that are so much a part of the integrated battlefield.

The only ultimate resolutions to crises of faith may be death, salvation, and eternal life. But this does not mean that UMTs should not offer those in crises of faith their assistance.

Resolution of crises of faith are important to healing and stabilization. Soldiers who have faith in centers of meaning and value heal better and faster. They remain calmer in the midst of great pain and trauma. They have a more positive attitude.

Not providing religious support to casualties suffering crises of faith limits soldiers to their own resources to deal with this most difficult of

issues. It deprives them of alternative perspectives which may better support resolution.

Soldiers without the UMT's religious support often struggle alone to make sense out of their experience. They have difficulty assigning it meaning. This struggle is often counterproductive to healing, stabilization, and return to duty as effective soldiers.

FEAR

Fear is a spiritual condition when it is related to ultimate realities, when it is related to ultimate meanings and values, when it is contextualized theologically, and/or when the primary coping resources are religious.

Psalm 23, "though I walk through the valley of the shadow of death, I will fear no evil," has been assisting both Christians and Jews to cope with fear for centuries. Jesus as a teaching rabbi exhorted his followers, "...do not fear those who can kill the body but cannot kill the soul (Matthew 10:28). And he said, "therefore do not be anxious about tomorrow, for tomorrow will be anxious for itself. Let the day's own trouble be sufficient for the day" (Matthew 6:34).

Faith in God, God's loving presence, God's power to intervene, God's protection, and God's involvement in producing positive outcomes are common to all religions. This religious faith helps sustain casualties when they are afraid. UMTs in their presence are models of faith and composure, as they share with soldiers the terrors of the battlefield.

Religious support helps calm fears by reminding soldiers of spiritual and religious resources that are available to them. It offers God's help, or the help of a power greater than self. Not providing religious support deprives soldiers of an important resource which will aid them in combating fear.

GRIEF

Soldiers experience grief following losses which they perceive as significant. Denial, sorrow, catharsis, anger, withdrawal, depression, and adjustment are some of the many possible responses to loss.

Some responses are healthier and more mature than others. Many of those who treat grief consider denial to be unhealthy, although it often helps prevent disabling grief. Many consider trivializing to be an immature response. Giving up or disabling depression is not supportive of sustaining soldiers in battle. Redirecting energies and adjustment are.

Grief may also be anticipatory, dwelling upon potential losses, both significant and seemingly insignificant. Some casualties are convinced that they will die, particularly if they return to fight again. Others fear disabilities or other losses.

Those experiencing grief usually require catharsis, or telling the story until it is purged of its horror, and including the loss within a framework of meaning and value to resolve grief. UMTs support casualties to develop theological world-views which afford meaning to experiences of loss. They assist casualties to reframe their experiences within contexts of faith and hope. They provide assurances of God's love, salvation, and eternal life.

Not providing this religious support deprives soldiers of opportunities for needed catharsis. It deprives soldiers of receiving helpful assurances of positive outcomes from representatives of religious communities.

GUILT

Persons who have made real or perceived mistakes which they deeply regret often experience guilt. Guilt is a spiritual condition when mistakes are labeled as sins and given an ultimacy that is spiritual. When soldiers give guilt this ultimacy, they require religious resources to resolve it.

Survivors often question why they lived and others died. They may regret actions that they did or did not take, and decisions that they did or did not make, that contributed to others' deaths. Medical treatment personnel sometimes regret triage choices that they made. Leaders sometimes take extraordinary responsibility for others, feeling guilty when others die or become casualties. Survivor guilt can be both limiting and disabling. It may impair future behavior.

Some casualties feel guilty about engaging in behavior which is incongruent with their life-style or values. They may feel guilty about sexual immorality or perceived atrocities which they witnessed, sanctioned, did not oppose, or committed. They may fear that they committed mortal sins which jeopardize their salvation. Casualties may perceive their suffering and death as punishment for sin and their sin as hastening their deaths.

Unit Ministry Teams provide opportunities for confession, prescribe penance, and proclaim God's forgiveness. As representatives of God and religious communities of faith, chaplains assist those who feel guilty to reconcile to both God and others. They provide spiritual resources when guilt is a spiritual condition which others cannot provide.

Not providing this religious support deprives soldiers of absolution by representatives of God and religious communities. Soldiers may so regret their past actions that they cannot forgive themselves. They may adopt an "I don't care" attitude or even a "death desiring" attitude, as if they deserve ultimate punishment. They lack the absolution that churches have traditionally provided as the answer to guilt.

DESPAIR

Casualties in despair have lost all hope. They feel that everything of value and meaning in their lives has been defeated. Everything seems futile, including life itself. They question the meaning and purpose of their losses and sacrifices. They may feel victimized, scapegoated, or dehumanized. They are disillusioned and cynical. Nothing is worth fighting and dying for. They hurt deeply.

Despair is a spiritual condition when soldiers relate it to ultimate meanings, values, and realities. They require religious resources to resolve it when they relate it to understandings of God, God's purposes, God's justice, or God's willingness to intervene.

Many of those in despair grieve and feel guilty. They see no hope beyond and no resolution of their suffering. They may withdraw, be angry, be suicidal, engage in self-destructive behavior, or take unnecessary risks. They may be psychically numb, emotionally anesthetized, and not care to join with others in accomplishing group goals and objectives.

Unit Ministry Teams provide religious support through being available as a supportive and caring presence. They suggest religious coping resources. They listen, assist in resolving related grief and guilt, and assist those in despair to recontextualize, reframe, or relabel their experiences theologically or philosophically. Recontextualizing or reframing is a process of integration in which a person accepts a traumatic event by assigning it another meaning or places it in another context which has less power to produce negative thoughts, feelings, and behavior.

Not providing this religious support deprives soldiers of needed encouragement to take "leaps of faith." When UMTs are not present on the battlefield, despair increases as soldiers begin to wonder if God cares enough to be with them in their suffering. They do not have a religious representative upon whom to vent their frustrations and make their complaints known. They have no religious authority to assure them that God does indeed care. They have no religious representative to point them in the direction of faith, hope, and love.

Recontextualizing or reframing experiences theologically or philosophically is almost impossible without the help of others. UMTs provide the resource. They confront immature and nonhelpful perspectives and offer more supportive ones. They offer a resource that only specifically designated representatives of communities of faith can provide.

CHAPTER V

MINISTRIES PROVIDED TO CASUALTIES

The eight different, yet interrelated and overlapping ministries that Unit Ministry Teams provide to casualties, as identified in the course of this study, are:

Ministry of Presence
Ministry to the Dying
Ministry of Sustaining
Sacramental Ministry
Crisis and Stress Ministry
Ministry of Guiding
Ministry of Worship
Ministry of Celebration

Each of these ministries is essential to maintaining physical, mental, emotional, and spiritual fitness. Each is essential to healing, stabilization, stress reduction, rapid recovery, and returning to duty. Soldiers who profess no religious preferences or leanings also benefit from them, particularly in times of crisis.

MINISTRY OF PRESENCE

In accordance with Forward Thrust doctrine, Unit Ministry Teams will be in combat with soldiers, experiencing most of the same risks and sacrifices. Although UMTs may not be at the point of wounding, they will be moving among units providing religious support to soldiers, including those who become casualties.

As proclaimed representatives of God and religious communities of faith, chaplains are symbols. Depending upon soldiers' religious backgrounds, traditions, or experiences, chaplains may be either positive or negative symbols.

Chaplains may be positive symbols for God's loving presence on the battlefield, God's identification with suffering, or God's wisdom. They may be symbols for transcending realities, meanings, and spiritual values. They may symbolize strength, composure, comfort, or peace which passes all understanding.

Chaplains may symbolize by their presence a willingness to sacrifice and give of themselves in service of others and/or the cause of peace. They may symbolize solidarity with God, others, and communities of faith.

Soldiers may view chaplains as sources of wisdom and insight because of chaplains' knowledge of sacred writings. Soldiers may view chaplains as those who through prayer can elicit powerful divine forces to intervene in battle to tip the balance in their favor or to alleviate suffering.

Some religious groups teach that priests and saints can intervene for soldiers before God, as soldiers themselves cannot.[1] Some teach that priests have divinely given authority to forgive sins. These groups include the Roman Catholic, Eastern Orthodox, Episcopal, and Lutheran churches, among others.

Chaplains may be symbols of faith, hope, and love in the midst of denial, hopelessness, and death on the battlefield. They may symbolize the possibility of new beginnings, a better future, and integration. They may symbolize spiritual devotion and focus. They may symbolize the humane. They may symbolize a believing acceptance of suffering.

Chaplains can also be negative symbols. They may be perceived as blessing the killing, the inhumanity, the immorality, the atrocities, and the brutalization of war.

One chaplain in Vietnam reportedly exhorted soldiers to kill others as a way of memorializing the dead or wounded. Some perceived this as promoting "false witness." Some soldiers may interpret what chaplains say as rationalizing or justifying combat experiences with the ultimate authority of the spirit.[2]

However chaplains are perceived, and no matter what symbols soldiers project upon them, chaplains are symbols which have power to influence attitudes, feelings, and behavior. Their presence can buoy spirits and strengthen morale or depress them.

Chaplains' dedication to presence, their willingness to take reasonable risks in ministering to others, and their behavior in combat can ameliorate how chaplains are perceived and what symbols soldiers project upon them.

Because so many soldiers project powerful symbols upon chaplains, merely the chaplain's presence with casualties can be supportive of healing, stabilization, rapid recovery, and return to duty. Chaplains need not do nor say very much to be effective, although hopefully they are both present and providing religious support of both word and deed.

RELIGIOUS NEEDS ASSESSMENT

A religious needs assessment precedes other ministries and is a quick rather than thorough spiritual diagnosis of casualties' spiritual conditions, religious needs, and religious resources as these relate to requirements for specific types of religious support. It is accomplished more by compassionate listening than by questioning.

Unit Ministry Teams attend first to casualties' physical and/or psychological conditions as they impact upon requirements for religious support and casualties' capacities for benefiting from it.

First, is the casualty dying, in extreme pain, traumatized, under extreme stress, soon going to undergo surgery, soon or not soon going to be evacuated, alert or confused, or suffering? Has the casualty suffered a significant loss? What are the casualty's needs, concerns, hopes, and fears?

Second, is the casualty suffering a spiritual condition: crisis of faith, fear, grief, guilt, despair?

Third, what are the casualty's spiritual needs? Are prayer, anointing, confession, absolution, sacraments, or distinctive religious group ministrations required?

Fourth, are the casualty's religious concerns superficial, compulsive/obsessional, profound/authentic, hostile/alienated, or sociopathic/manipulative?[3]

Fifth, what religious resources or other spiritual sources of comfort and/or support does the casualty have? What knowledge does the casualty have of sacred writings? Does the casualty require some religious literature to read or some religious symbol to carry?

Sixth, does the casualty need an invitation to religious services or study groups? Should the casualty be referred to other helping professionals? Does the casualty need followup visits?

Seventh, what are the overall pastoral impressions and recommendations?

UMTs best accomplish this religious needs assessment shortly after casualties arrive at a medical treatment location. This assessment provides the basis for other ministries and assists chaplains to use their time and energies most efficiently. Chaplain assistants can assist chaplains by doing this assessment, particularly during times when the chaplain is involved elsewhere.

Not doing this assessment would decrease the UMT's effectiveness. UMTs would not have any basis upon which to determine priorities for religious support to casualties nor a way of determining specific religious concerns and needs. Without it, they may spend their time and energies where they are not most needed.

MINISTRY TO THE DYING

As individual beliefs and stages of faith differ, so do the spiritual needs of the dying. Different spiritual needs require different pastoral interventions.

The dying who have immature, childlike faith that contains fantasy, and images of death that are filled with terror, punishment, and destruction,[4] require religious support that reassures them of God's love and mercy.

Those who base their faith upon a system of reciprocal fairness, i.e. rewards for good behavior and punishments for bad,[5] need reassurance that they have not necessarily done anything to deserve death, and that God is loving and merciful.

The dying who have a strongly interpersonal faith, which may be conventional and non-analytical,[6] need assurance that God will be as much of a friend in death as God was in life, that God can even use death to accomplish God's good will.

Those whose faith is a function of their personal identity shaped by their own experiences and critical reflections upon life's meanings and values,[7] require support for experiencing death as self-actualization. They also require assurances that there is life beyond death.

Those for whom faith is a way of seeing, knowing, and committing which recognizes the complexity of life and its meanings, the interrelatedness of everything, and the partiality of truth,[8] require support in accepting death within a framework or context of partial meanings, of paradoxical understandings of truth, and of irrevocable acts and commitments.

Those who have a comprehensive vision of truth which transcends parochial perceptions of justice, who embrace universal community, who are not concerned with relevancy, and who seek to transform present realities in the direction of transcendent realities,[9] require affirmation of their vision and appreciation for their willingness to sacrifice in compassionate service of others and for the sake of universal principles.

The pastoral goal is to affirm each dying soldier, regardless of his/her stage of faith, in faith and perspectives that assist acceptance of the reality of death and which ease the transition from life through death.

Soldiers' death perspectives are related to their images of God. If they perceive God as powerful, near, merciful, and caring enough to intervene in present or future life, they perceive God as aiding the transition through death. If they perceive God as impotent, far off, vengeful, and unwilling or unable to intervene in present or future life, they perceive God as not helpful at the time of death.

Death perspectives also relate to past experiences of faith. Soldiers who have experienced God intervening in past crises or confrontations with death, as answering prayers for help, and as self-revealing in crisis, will look to God for help and meaning.

Some soldiers will have learned helpful ways to contextualize or frame their experiences theologically. Others will have experienced the helpfulness of solidarity with religious communities of faith. These experiences are

resources which can aid the transition. UMTs affirm their helpfulness and may elicit their memory as a way of assisting the dying.

Unit Ministry Teams address spiritual conditions: crisis of faith, fear, grief, guilt, and despair. As the dying experience crises of faith and/or question the possibility of their own salvation or religious teachings concerning death and eternal life, UMTs assist them to embrace belief systems, world views, and theological values and meanings that aid them to accept death within the context of life and its meanings.

UMTs encourage the fearful by eliciting inner religious resources, affirming God's caring presence, and providing answers to questions involving fear as answers are known.

As the dying grieve their losses, UMTs listen compassionately and empathically, affirm the dying's contributions to life, and assure the dying of God's care for families, friends, life purposes, and goals.

UMTs assist the dying who feel guilty to contextualize sin theologically. They provide opportunities for confession, penance, and absolution. They assure them of God's forgiveness. UMTs help the dying make peace with God and others. They affirm individual worth and dignity. They provide supporting sacraments and other religious ministrations and rites.

UMTs encourage those in despair to take leaps of faith. They encourage them to believe that they have not been forsaken. They proclaim that God does indeed care. Many teach that death can be transcended, and that there is hope beyond.

Ministry to the dying assists the dying to prepare for death, have courage to face it, and find meaning in it.[10] The pastoral goals are: that soldiers include death within a universe of values and meanings, that they experience confirmation of their solidarity with God and others, and that they experience spiritual wholeness, thanksgiving, and even a quiet joy in dying.

UMT tasks include: being there, listening empathically, facilitating expression of thoughts, feelings, and visions, hearing frustrations and anger, sharing the suffering, and sharing religious resources and spiritual insights.

UMTs provide a spiritual resource that facilitates exploration of theological issues, values, and meanings. They provide human contact, touch, and appropriate holding for the dying who "die in their arms." They assist the dying to order their last affairs, say goodbye, and bestow blessings on others. They pray for and with the dying. They discuss future hopes. They communicate divine grace and promise.

Not providing this religious support deprives soldiers of religious resources at the time of their ultimate sacrifice. Without it, it is less likely that they will die at peace with God, others, and themselves. It is more likely that they will die feeling forsaken and alone. According to some religious traditions, not receiving required religious support, namely sacraments, may even affect the future state of their souls.

MINISTRY OF SUSTAINING

UMTS provide the ministry of sustaining to those for whom total healing or restoration to former conditions of wholeness are not possible, or at least not in the near future.[11] They provide this ministry to casualties whose condition will not soon or ever change very much. They also provide it to casualties who are suffering irreversible losses or processes of degeneration or impairment.[12]

Those who benefit most from this ministry include: quadriplegics, paraplegics, amputees, the disfigured, those who have significant brain or organ damage, those who must use machines to sustain life, and those with disabilities projected to be permanent.

The pastoral goals are: to assist these casualties to transcend their circumstances in the direction of healing and hope,[13] to prevent the experience of the tragedy from destroying their faith in God and other centers of value and meaning, and to assist them to find courage to confront and/or live with their disabilities.

UMTs accomplish sustaining ministry by forming partnerships with casualties, They "lend" composure, courage, faith, wisdom, insight, spiritual maturity, and peace of God to those who are suffering, who "lend" their fears, frustrations, anger, doubts, and/or despair to the relationship.[15] Those who are temporarily stronger support those temporarily weaker. Henri Nouwen calls this entering into solidarity with others.

UMTs offer soul friendship, unconditional acceptance, compassionate listening, accurate empathy, faithfulness, loving and caring presence, mutual respect, and connectedness with a community of faith. They offer being there, being with, and being for those suffering.

UMTs offer comfort, most often through silent companionship. Casualties may perceive verbal reassurances as simplistic, unrealistic, falsely reassuring, or demonstating a lack of empathy or understanding of the gravity of the situation.[16]

UMTs affirm the intrinsic value, innate dignity, and unalienable worth of casualties. They attempt to elicit inner resources which can help these casualties sustain themselves from within. They assist catharsis and expressions of casualties' inner selves, including needs, wants, feelings, interpretations, and visions of the future.

UMTs also share their own faith, insights, and hopes. They refuse to be discouraged with casualties. They encourage self-initiative and independence in so far as they are possible.

UMTs aid the biblically referenced progression (Romans 5:3-5) from suffering, to endurance, to character, to hope that does not disappoint. UMTs struggle continually with what it means to bear others' burdens. They collaborate with casualties in making tough decisions. They remain faithfully present as situations permit.

It is a paradox that real sustaining emerges only when the direction of this ministry toward future healing as a possibility, however remote, and the force of present circumstances are both recognized.

Hope is compensatory or illusory if healing is not offered as a possibility. Denying present circumstance or identifying hope only with future healing may build unrealistic expectations. Entirely futurizing hopes may impede the present work of healing. Having only present hopes impedes future hopes.

Not providing this religious support deprives severely injured soldiers of a resource which may mean the difference between their acceptance of life with all its potentials and despair. Living with serious disabilities is often more difficult than dying. Some disabled soldiers even desire death rather than life with disabilities. Religious support is often helpful to countering this attitude.

The disabled must transcend circumstance in the direction of healing and hope in order to develop fully their potentials. This requires all available help, including spiritual help.[17] The UMT is an essential hope supporting resource to those who must adjust to both permanent and temporary disabilities.

SACRAMENTAL MINISTRY

UMTs provide sacramental ministry as requested by casualties, usually within the constraints of both chaplains' and soldiers' religious traditions. Soldiers in past wars, however, have received sacramental ministry on the battlefield from chaplains not of their own religious tradition or groups.[18] Some religious groups permit both reception and administration of sacraments to other than members of their own religious groups in extraordinary circumstances.

Protestant sacraments, rites, and other ministrations include: Baptism, Holy Communion, Confirmation, Affirmation of Faith, Service of Healing, Anointing of the Sick, Laying On of Hands, and other Blessings.

Roman Catholic sacraments, rites, and ordinances for the sick and dying include: Communion of the Sick; Anointing of the Sick; Viaticum; Commendation of the Dying; Prayers for the Dead; Continuous Rite of Penance, Anointing, and Viaticum; Rite for Emergencies; Christian Initiation for the Dying; and Rite for Reconciliation of Individual Penitents.[19]

Eastern Orthodox sacraments, rites, and other ministrations include: Sacrament of Holy Unction, Communion, Confession, Prayers for the Sick, Thanksgiving for Recovery, Prayers for the Dying, Absolution of the Dying Person, Prayers for the Person Condemned to Death, Prayers After Departure of the Soul from the Body, the Litany of the Deceased, and the Internment of the Dead.

Jewish tradition specifically views the period of dying and terminal illness as a time of "getting one's house in order," blessing one's family, and making peace with God. The deathbed confessional is an important element in the transition to the world to come.[20] As Rabbi Zachary Heller concludes:

> Spiritual pain, then for the Jewish patient, could include any accidental thwarting of his or her reconciliation with God, any blocking of confession, or any interference with the ordering of the patient's last affairs, the blessing of the family, and the passing on of ethical imperatives as laid down in the finest of Jewish law and tradition.[21]

CRISIS AND STRESS MINISTRY

UMTs provide crisis and stress ministry to all battle fatigue casualties, and to other casualties experiencing stress in addition to other wounds, injuries, and diseases.

Unit Ministry Teams promote development and reinforcement of inner strengths, resources, belief systems, world views, value systems, frameworks of meaning, and faith that will aid soldiers in coping with the chaos and horrors of battle. They offer opportunities for spiritual renewal, worship, study, and receiving sacraments.

UMTs support good nutrition, adequate rest, physical fitness, and strong interpersonal relationships as essential to maintaining the morale and total well-being that prevent disabling stress and fatigue.

UMTs may teach stress reduction strategies, such as: prayer, reframing, and creative visualization. They may teach communication skills to strengthen interpersonal relationships and support unit cohesion.

UMTs affirm behavior congruent with personal and social values in order to reduce the incidence of disabling guilt. They teach perspectives toward death to aid soldiers in facing the possibility of their own deaths and reduce disabling grief. They provide Scriptures, sacred writings, other religious literature, and religious symbols for soldiers to carry with them.

Pastoral care tasks in ministry to battle fatigue casualties include: assisting emotional and spiritual catharsis, reframing, and assigning appropriate meanings to experiences. UMTs assist casualties to debrief and review their experiences objectively. They assist closure and integration. They confront secondary gain issues and work to limit overdramatization and unhealthy interpretations.

UMTs proclaim hope for the future and forgiveness for the past. They encourage and enhearten soldiers who are returning to duty.

Not providing this religious support deprives soldiers of important stress reduction resources. These include preventive resources as well as crisis intervention resources.

UMTs often introduce soldiers to coping resources previously not considered. They share religious perspectives which aid soldiers in developing the belief systems and theological frameworks which will assist them in coping with the brutalization and sacrifices of the integrated battlefield.

MINISTRY OF GUIDING

UMTs provide the ministry of guiding to casualties who are in ethical, moral, or spiritual dilemmas, value conflicts, and interpersonal conflicts, particularly as they affect healing, stabilization, stress reduction, morale, unit cohesion, esprit, organizational effectiveness, and leadership capacities. They also provide it to medical treatment personnel caring for casualties.

The goals of this ministry are: (1) to provide soldiers and leaders with the best available knowledge and resources for effective decision making, conflict resolution, and problem solving; and (2) to reinforce normative standards and criteria congruent with personal and cultural identity, value systems, and meanings.

The three basic forms of this ministry are inductive, eductive, and collaborative guidance.

Inductive guiding is leading others to adopt a priori sets of values and criteria by which to make decisions.[22] UMTs give soldiers a structure, a character, an identity, and a religiocultural value system out of which to live.[23] They define alternatives. They offer direction and/or advice.

This form of guidance is most appropriate for soldiers lacking strong or healthy value systems, world views, belief systems, or frameworks of meaning.

Eductive guidance is eliciting criteria and resources for decision making from soldiers' own values and experiences. UMTs educe moral and ethical solutions from that which are internal goals, values, and norms.[24] The goal of eductive guiding is to assist troubled persons to clarify or reshape their responses within their own value frameworks.

Eductive guidance is most appropriate for those who have strong or healthy internalized value systems, world views, belief systems, or frameworks of meaning, and for those who are part of a clear moral context which has a fund of normative values and meanings.[25]

In providing this religious support, UMTs provide supportive relationships of acceptance, empathy, and respect, which are non-directive, and which concentrate upon dynamic, motivational, and emotional issues.

Collaborative guidance, a combination or synthesis of inductive and eductive guidance, affirms both internal and external resources, value systems, world views, belief systems, and frameworks of meaning. The goal of collaborative guidance is to work out collaboratively a mutually shared universe of relevant values and meanings.

Collaborative guidance is most appropriate for those in transition, for those whose previously accepted values, beliefs, and meanings are inadequate for coping with current experience, for those open to considering yet other perspectives and alternatives, and for those who recognize the complexity of systems, the partiality of truth, and the paradoxical nature of the universe.

MINISTRY OF WORSHIP

UMTs provide the ministry of worship to casualties during lulls in the battle and at medical treatment facilities. UMTs lead soldiers in prayer, praise, thanksgiving, meditation on sacred writings, and recommitting themselves to religious life.

The pastoral goal is to strengthen, enlighten, and inspire soldiers spiritually. In worship, the Word of God works to create and preserve faith, hope, and love.[26] The Good News of God's activity in our world is a Word of life that frees and reconciles.[27]

For some religious groups, soldiers receive in worship the unconditional grace of God that forgives all choices that must be made in combat. Battlefield situations may force soldiers to choose between what is bad and what is worse.[28] Worship empowers soldiers to serve to the limits of human endurance in battles that defy all sense, are basically evil, and have all the marks of judgment. Worship leaders proclaim forgiveness and encourage faith.

For some soldiers, forgiveness enables them to do what they must do without fearing eternal damnation.[29] Faith enables them to trust in God's ultimate victory and salvation, no matter what happens to them personally on the battlefield.[30]

Worship together strengthens unit cohesion, as soldiers join together in mutual support and worship a common center of value and meaning.

UMTs often individualize worship with casualties at the point of wounding, at casualty collection points, at the bedside, or on patient wards. They may conduct worship in dining facilities, supply tents, under the trees, or in areas designated as chapels. They may provide worship for entire units, as in memorial services. Or they may provide worship only for members of the particular religious group that they represent.

On the battlefield, where religious resources are limited, worship is almost always nondenominational and offered to all. Its content and length may vary considerably. Worship may be conducted according to a prescribed liturgy. Or it be tailored to specific needs. Its basic ingredients are: prayer, sacred readings, meditation, doxology, assurances of God's grace and blessings, and oftentimes music.

Not providing this religious support deprives soldiers of the strengthening effects of collective religious services of worship. It deprives units of an activity that helps build unit cohesion. It deprives soldiers of

collective opportunities to share their grief and honor their fallen comrades in memorial services. It deprives them from receiving sacraments most often offered in collective services.

MINISTRY OF CELEBRATION

UMTs provide the ministry of celebration to soldiers and casualties who are thankful that they have survived the battle and/or that their wounds and injuries are not more serious or disabling. They provide this ministry to soldiers and units who are celebrating the victory of battle, especially when they achieve victory at no great cost in human lives or injuries. UMTs also provide this ministry to soldiers going home.

UMTs lead celebrating soldiers in prayers of thanksgiving and praise to God for protecting them on the battlefield. They pray with and for soldiers' for continued healing and blessings. They share soldiers' joys as well as their sorrows.

Not providing this religious support deprives soldiers of an opportunity to say their appreciation publicly, to share their faith that got them through, and to praise and honor those who supported them in combat. This ministry supports morale and unit cohesion.

CHAPTER VI

DOCTRINE

The First Amendment of the Constitution guarantees soldiers' rights to the free exercise of their religious faith wherever they live, work, or fight. Military regulations also support these rights. Only the needs of the combat environment or the military unit's mission limit them.

Commanders are responsible for the religious, spiritual, moral, and ethical well-being of all military personnel within their command. Chaplains are commanders' primary staff officers, advisors, and consultants on matters pertaining to religious life, morals, and morale as affected by religion.

The Unit Ministry Team's primary mission is to provide religious support to soldiers in combat. The three-fold mission is:

To nurture the living
To care for the casualties
To honor the dead[1]

UMTs provide religious support through pastoral ministry, which is defined as supporting the spiritual life of soldiers. According to doctrine, they accomplish this ministry through conducting religious services, administering rites, visiting, comforting, and encouraging.[2]

"Forward Thrust" is the Army doctrine designed to provide effective religious support on the AirLand battlefield. Religious support is pushed forward to smaller, more exposed elements of the task force. This doctrine requires assigning UMTs down to battalion and equivalent size units.

The value of habitual personal contact with soldiers increases as the lethality and the intensity of the battle increase. Requirements for ministry increase when soldiers experience mass casualties, hasty burials, and isolation.[3]

The phases of battle influence what ministries UMTs provide and how they provide them. UMTs within a particular area of operations enhance religious support to all units within the area by sharing religious coverage rasponsibilities, particularly during the battle phase when they have limited mobility.[4]

During the pre-battle phase, UMTs provide religious support to soldiers experiencing pre-battle anxiety or fear. They provide counseling, encouragement, and spiritual reassurance.

During the battle phase, chaplain doctrine states that the priority for religious support is to casualties. At the last practical moment, UMTs move to

positions where the largest numbers of casualties are to be collected, usually battalion aid stations.

Depending upon METT-T, UMTs may move around on the battlefield rather than wait at a single casualty collection point. Or they may focus their support at the casualty collection points of the most heavily engaged units.[6]

Doctrine is deficient at this point. Prepositioning or fixing UMTs at casualty collection points would too greatly limit religious support to all soldiers, both casualties and noncasualties. Soldiers who are not casualties require religious support to help sustain them in battle. They require the chaplain's supportive presence, prayers, and encouragement.

Soldiers who are not casualties require the same ministries as casualties. They require religious support as they confront the possibilities of their own deaths or injuries. They require a ministry of sustaining when situations do not get better. They require crisis and stress ministry when they face the chaos, horror, and brutalization of the modern battlefield.

Soldiers require the ministry of guiding when they confront ethical dilemmas. They require a ministry of worship as they prepare for battle and during lulls. They require opportunities to celebrate within a religious context.

Soldiers who are not casualties may suffer the same spiritual conditions as casualties. They may lose confidence in centers of value and meaning. They may question their purpose, their leaders, or how much the system cares. They may question God's justice, care, potency, and willingness to intervene to help them. They will probably be afraid. Many will grieve losses. Some will experience guilt. Some will despair.

Making religious support to casualties the priority during the battle phase undervalues other soldiers' needs. These other needs may require priority, if UMTs are to provide the best possible religious support to all soldiers on the battlefield.

The threat will affect mobility during both battle and pre-battle phases. If religious support to casualties is the priority, UMTs would have difficulty deciding exactly when to move to casualty collection points. Prematurely prepositioning UMTs at casualty collection points would effectively deny religious coverage across the battlefield during the pre-battle phase to soldiers preparing for battle.

If casualties do not receive religious support within battalion areas, they will receive it in areas to the rear. Brigade, division, and corps UMTs are responsible for casualties evacuated to the rear.

The brigade chaplain ensures that continuous coverage is provided to all casualty care points within the brigade area of operations. The brigade chaplain also coordinates area coverage in the task force area of operations or in areas of nuclear, biological, or chemical contamination.

In the event of mass casualties, the task force chaplain analyzes the situation and decides whether to move to the casualty site or to the casualty collection point. The division chaplain monitors casualty data reported to the division level. The division chaplain ensures that the appropriate brigade and battalion UMTs are aware of the implications of this data for effective ministry to soldiers and their families.[7]

During the post-battle phase, the priority for religious support is to soldiers suffering from stress and trauma.[8] During lulls, UMTs provide small group counseling and services.[9] During withdrawals UMTs risk capture or death if they choose to remain behind to minister to casualties.[10]

During reconstitution, UMTs console the living, conduct intense individual and group counseling, and conduct brief services to honor the dead.[11] When hostilities end, UMTs provide intensive pastoral care for both casualties and noncasualties and conduct more formal honors for the dead.[12]

"Battle Fatigue Ministry" (Field Circular 16-51, September 1986) describes UMT battle fatigue doctrine. This ministry's goal is to assist soldiers experiencing the chaos of the battlefield to achieve emotional and spiritual strength and wholeness. UMTs provide preventive, immediate, and replenishing emotional and spiritual support to soldiers who are experiencing the trauma and stress of combat.[13]

Spiritual ministrations include:

- Praying for the soldier
- Praying with the soldier
- Worshiping with soldiers, individual and in small groups
- Performing sacraments, rites and ceremonies with the soldier (within ecclesiastical guidelines)
- Expressing forgiveness on behalf of the soldier
- Forgiving listening to soldiers
- Visiting soldiers - where they work, train, play, eat, live
- Counseling with soldiers
- Sharing concern for the soul of the soldier[14]

During predeployment, UMTs concentrate upon developing supportive relationships, training for combat, taking preventive measures, and helping soldiers deal with the uncertainty of the future and the fear of failure and death.[15]

During deployment, UMTs stay present with soldiers as they deploy together, provide opportunities for corporate prayer, worship, and study, visit staging and work areas, and talk with soldiers to facilitate their working through stress.[16]

During prebattle, UMTs continue to strengthen and develop relationships with soldiers, provida worship opportunities, offer encouragement, and provide personal and pastoral counseling.[17]

During the battle phase, UMTs perform "religious triage," minister to the wounded and dying, facilitate peer counseling, reinforce soldiers' senses of personal worth and hope, and identify specific spiritual needs of soldiers and their leaders.[18]

During postbattle, UMTs coordinate religious support, facilitate the grief process, reaffirm soldiers' senses of personal worth and hope, structure opportunities for soldiers to talk about what they have experienced in combat, facilitate the integration of the combat experience in their lives, and participate in rebuilding the physical, emotional, and spiritual resources of the unit.[19]

Following the end of hostilities, UMTs provide worship events, provide structured events to assist soldiers for reentry into family and civilian life, and provide opportunities for soldiers to understand the forgiving and unchanging love of God.[20]

UMTs provide memorial services which emphasize the transcendent element of hope--hope for a better future, new beginnings, and the integration of the past. Memorial ceremonies emphasize the presence of God through the sharing of human concern and spiritual faith.[21]

HEALTH SERVICE SUPPORT DOCTRINE

Health service support doctrine does not reference religious support. Emerging interim operational concepts and current and draft Tables of Organization and Equipment contain only brief descriptions of the duties of chaplains and chaplain assistants.

Emerging health service support doctrine proposes some changes in how and where casualties receive medical treatment which have implications for religious support to casualties.

First, emerging doctrine proposes making extensive use of combat lifesavers. These are usually junior noncommissioned officers or assistant squad leaders who have enhanced first aid training. They assist combat medics to provide medical treatment at the point of wounding.[22]

Since as many as one out of every eight soldiers or one soldier per squad will be trained as a combat lifesaver, some have considered training UMTs to be combat lifesavers.[23] But this is not recommended.

UMTs having combat lifesaving as a secondary function would conceivably enhance their usefulness on the battlefield. UMTs would not only be providing religious support to casualties, but also lifesaving medical treatment. This would free other combat lifesavers to fight the battle, service equipment during lulls, or attend to other tasks supportive of continuing the battle.

But using UMTs as combat lifesavers undervalues the religious support that they provide to soldiers. It could dilute the religious support. UMTs could become so involved in providing medical treatment to a few that they would be

constrained from moving from casualty to casualty and in providing essential religious support to the many.

Chaplain assistants could become so involved that they would not be available to support chaplains in "religious triage" or move with chaplains to points on the battlefield where they are most needed. Religious support to other than casualties could be constrained.

Religious support helps sustain soldiers through periods of great trauma.[24] As UMTs provide it to as many soldiers as possible, it supports healing, stabilization, rapid recovery, and return to duty. Primary religious support must never be diluted. UMTs will have enough to do on the battlefield without being designated as combat lifesavers.

All UMTs should be highly proficient in first aid which is often lifesaving. They may even wish to familiarize themselves with medical treatment procedures. My recommendation is only that assigning combat lifesaving to UMTs as a secondary function not become doctrine.

Some have even suggested training up UMTs to be combat medics. The Army should reject this proposal for the same reasons.[25] In a mid-high intensity conflict, providing medical treatment to a few would quickly become a primary function which would constrain UMTs from providing essential religious support to the many.

Second, emerging health service support doctrine proposes dividing battalion level medical treatment squads into two teams to maximize far forward medical treatment.[26] Doctrine proposes positioning them at two different locations.[27] Each team would have either a physician or a physician's assistant, one emergency treatment noncommissioned officer, and two medical specialists.

Since casualties receive treatment at many locations, prepositioning or fixing UMTs at any one location limits potential religious support. If UMTs preposition or fix themselves at one location, casualties treated at other locations would not receive religious support prior to evacuation.

Prepositioning would also limit religious support to noncasualties. UMTs must have the capability of moving among many treatment locations. They must be free to provide religious support to all soldiers on the battlefield.

Since these treatment locations will be deployed as close to the FLOT and points of wounding as the tactical situation permits, UMTs at these locations will be vulnerable to becoming casualties themselves.

One of the doctrinal implications is that brigade, task force, and other rear area UMTs must prepare to provide initial religious support to casualties evacuated from forward areas. They will provide this in addition to providing religious support to casualties wounded in rear areas. Doctrine should be changed to reflect this factor.

Brigade and higher level UMTs must also prepare to augment religious coverage in battalion areas of operations when battalion level UMTs become casualties.

Third, emerging health service support doctrine positions medical clearing or treatment stations in brigade areas of operation.[28] These locations will require religious coverage. Brigade UMTs would best provide for this coverage.

Fourth, emerging health service support doctrine proposes establishing holding areas both for casualties requiring minimal care before returning to duty and contaminated casualties.[29] As emerging doctrine projects that these holding areas will be in the corps area, they will require religious coverage from corps UMT assets. If they are collocated with corps hospitals, hospital chaplains could provide this coverage. If not, other UMTs must provide this coverage.

Fifth, emerging health service support doctrine proposes establishing combat stress control units to provide consultation, intervention, and treatment for battle fatigue casualties. Emerging doctrine proposes that each combat stress control platoon have a chaplain, but no chaplain assistant.[30] Not having a chaplain assistant constrains chaplains from providing full religious support.

Recent chaplain branch doctrine establishes battle fatigue ministry as a Unit Ministry Team function. Doctrine should reflect that in the Combat Stress Control unit, only chaplains will provide this ministry. No other changes in chaplain branch doctrine is necessary at this time.

Sixth, emerging health service support doctrine envisions times when medical units will be only partially deploying as modules. Situations may require only partial units.[31] These modules or partial units may not include one or more members of UMTs organic to medical units. Casualties would therefore receive initial religious support after evacuation from the battlefield. Rear area UMTs may be the first to provide this support.

CHAPTER VII

ORGANIZATION FOR COMBAT

Unit Ministry Teams organic to maneuver units provide religious support in the combat zone. Combat support and combat service support UMTs will provide area coverage in addition to supporting their own units.

Since UMTs organic to medical units are not usually located in maneuver battalion or brigade areas of operation in the combat zone, they cannot provide area religious support for casualties in the combat zone. UMTs remaining with medical units during withdrawals to care for casualties may provide some area support.

During mass casualty situations, when holding areas are established for casualties awaiting treatment or evacuation, the task force chaplain analyzes the situation and decides whether to move to the casualty site or to the appropriate casualty collection point.

The brigade chaplain coordinates area coverage in the task force area of operations or in areas of nuclear, chemical, or biological contamination.

Task force UMTs provide religious support to task force ministry teams without waiting for them to request it. The task force UMT handles protocol for area coverage teams. However, each area coverage team arranges the details to carry out its own daily activities during such emergencies.[1]

Medical treatment teams often triage casualties as they admit them to the treatment area. They classify them as: "immediate," "expectant," "delayed," or "minimal." They do this not only in mass casualty situations, but also when they must admit several casualties in a relatively short period of time.

They classify as "immediate" those casualties requiring immediate treatment to save life or limb. They may classify as many as 20% as "immediate." These casualties receive medical treatment first. Medical personnel then place stabilized "immediate" casualties in holding areas to await evacuation. They then may reclassify them as "delayed."[2]

The UMT's initial religious support to casualties triaged as "immediate" may be only a brief contact in the admitting area. The UMT may only have enough time to provide brief blessings, prayers, and words of encouragement or comfort. Many of these casualties will be unconscious, highly medicated for pain, disoriented, or confused. This affects what religious support UMTs can provide.

Chaplains who served hospitals in Vietnam report their ministry to "immediate" casualties to be one of presence, doing anything to save and

preserve lives, answering simple questions, praying, moving among the wounded, comfort, last rites, or "a little of everything."[3]

Treatment personnel classify as "expectant" those casualties whose possibilities of survival are miniscule, even if the best medical treatment is available. They may classify as many as 20% as "expectant."

Medical teams relate to these casualties with alertness (expectancy) to changes in their conditions. They primarily provide supportive care and pain relieving medications, until more extensive medical resources are available or they can provide more intensive lifesaving medical treatment.[4]

Treatment personnel must often make painful but necessary medical decisions which deprive the "expectant" of extensive medical treatment when others have greater chances of living with less extensive treatment. The guiding ethical principle is providing the greatest good for the greatest number.[5] Medical personnel place the "expectant" in holding areas to await either death or evacuation. They may not assign them the highest priority for evacuation.

UMTs may choose to give priority for religious support to the "expectant." During mass casualty situations, treatment personnel may not have much time to spend with these casualties. Setting them aside may mean not paying them much attention.

Whereas these casualties may be unconscious, suffering high levels of pain, disoriented, and confused, they require religious support designed specifically for the dying. These include: the Viaticum, Anointing, prayers, Communion, or perhaps emergency Baptism. Many require someone just to be with them, a ministry of sustaining.

Hospital chaplains who served in Vietnam report that their ministries to the "expectant" included: praying, comforting the dying, sitting in silence, answering simple questions, touching, making self available, and providing last rites.[6]

The UMT's presence is even more important when medical treatment staff are busy treating others. The "expectant" may feel abandoned by others. They need continual reassurance that others, including God, care enough to be with them in their dying.

Medical personnel classify as "delayed" injured or wounded casualties whose medical treatment can be delayed after receiving minimal emergency medical treatment. They may classify as many as 20% as "delayed."[7]

They may "delay" medical treatment due to a scarcity of medical resources, such as: required expertise, materiel, or equipment at the triage location. They place "delayed" casualties in holding areas until they can be evacuated. The evacuation priority for "delayed" casualties' is high when medical resources required for saving their lives or limbs are available elsewhere.

Ministries provided to the "delayed" include: ministries of presence, sustaining, and/or crisis and stress ministry. Whereas UMTs may not give these casualties the highest priority, these casualties often are the most receptive to supportive ministries. Important ministries include: moving among them, offering words of encouragement, answering questions concerning when they might be treated or evacuated, and offering prayers, sacraments, and rites.

Medical personnel classify as "minimal" those casualties whose injuries or wounds are minimal.[8] These casualties may require only first aid or minimum medical treatment prior to their return to duty. Approximately 40% of all casualties may require "minimal" treatment.

Medical teams evacuate these casualties only if their projected recovery time exceeds the area evacuation policy. They may place these casualties after treatment in holding areas for rest and/or until their units can pick them up. They may place them in holding areas for battle fatigue casualties if they suffer this condition.

UMTs usually give "minimal" casualties the lowest priority. The "minimal" may benefit greatly from crisis and stress ministry prior to their return to duty, particularly if they are suffering from battle fatigue.

Since by definition mass casualty situations are those in which requirements exceed capacities to provide medical treatment, it is impossible to organize or provide an adequate force structure for mass casualty contingencies. However, both units and UMTs can establish and coordinate mass casualty plans for their units and areas.

UMTs may coordinate with other task force UMTs to provide religious support in mass casualty situations to various holding areas for which organic UMTs are unable to provide religious coverage. Several different areas may require religious coverage. When mass casualties are evacuated to corps hospitals, hospital UMTs may also require augmentation.

Therefore my recommendation is that every unit and division have its own coordinated mass casualty plan. If the tactical situation permits other UMTs to be available, particularly to provide distinctive religious group ministrations, they should be used to provide additional religious support in mass casualty situations.

Reserve forces UMTs or TOE 16-500 teams assigned to divisions to augment religious coverage in divisions could provide religious support for mass casualty holding areas. Or brigade, task force, and/or division chaplains could task organize other UMTs to provide this coverage.

NBC warfare adds another dimension to religious support. It produces not only mass casualties, but also contaminated environments which limit capacities to provide religious support.

Health service support planners have not yet projected numbers of NBC casualties. Nor have they developed a patient condition classification system

for NBC casualties. Therefore projecting an adequate UMT force structure for NBC contingencies is not possible at this time.

The Chaplain Corps should begin a separate study which addresses religious support to NBC casualties. UMTs have no combat experience in NBC environments. NBC warfare is continually changing. NBC weapons are changing in lethality, effects, and how they are used. Relevant threat factors are continually changing. Protective measures are also changing, as are protective clothing and shelters. These developments require separate study as they impact upon requirements for religious support.

Some units do not have organic UMTs. Since all units on the integrated AirLand battlefield are vulnerable to attack and will experience casualties, all units require religious coverage if their casualties are to receive essential religious support.[9]

My recommendation is that division chaplains coordinate religious support to casualties within division areas of operation in the combat zone. Corps and other senior command chaplains should coordinate religious coverage to casualties in the COMMZ and at EAC.

Distinctive religious group coverage will be difficult to provide on the integrated battlefield. Threat factors limit movement over broad areas. Chaplains represent many different religious groups. Some religious groups, such as Roman Catholics, are underrepresented.

Assigning Roman Catholic chaplains to area coverage within divisions is one way to manage this shortage. Locating Roman Catholic chaplains at points where the most casualties will require emergency ministrations is another option. Fixing them at one location or restricting their movement on the battlefield would too greatly limit their religious support. Echelon III and Echelon IV medical facilities also require Roman Catholic religious support.

Assigning Jewish and Eastern Orthodox chaplains to area coverage within corps is one of the ways to manage religous coverage for Jewish and Eastern Orthodox soldiers. Placing them within the evacuation stream is another option. They also must be free to move on the battlefield as the tactical situation permits.

Assigning to divisions as great of a mix of Protestant chaplains as possible is the best way to manage Protestant religious coverage requirements. Division UMTs can best coordinate requests for denominational ministrations within division areas of operations.

Corps UMTs can best coordinate requests for specific religious group ministrations from Echelon III and IV medical facilities. Combat support and combat service support UMTs from within the corps can best provide this support.

UMTs can only provide area coverage as the tactical situation permits. Chaplains from other religious groups may provide religious support to

casualties of other than their own religious groups. When the tactical situation restricts area religious coverage, this is the next best alternative.

A staff study conducted in April, 1962, by Chaplain Samuel Graves, at the U. S. Army Chaplain Center and School, which surveyed 10 Roman Catholic and 21 Protestant chaplains, concluded that there are many ministries that Roman Catholic and Protestant chaplains can provide for members of each others' groups.[10]

All chaplains provide religious support to casualties according to the dictates of their own consciences and in keeping with the religious traditions that they represent.[11] Religious support in high stress combat environments, however, frequently transcends religious differences.

General Bernard C. Rogers once wrote:

> Army chaplains in the field have always been more than just representatives of their particular faith. To a soldier in need of spiritual comfort, a chaplain was a chaplain whether minister, priest, or rabbi. It is common to hear soldiers of one faith praise chaplains of another faith who were there when it counted.[12]

As UMTs organize for combat, it is essential to affirm the roles and functions of chaplain assistants. Chaplain assistants on the AirLand battlefield provide religious support to casualties which brings them into direct contact with casualties. They also provide much essential religious support that does not bring them into direct contact with casualties. Not providing this support would seriously constrain religious support that chaplains provide.

MOS specific training qualifies chaplains assistants for specific religious support tasks. These include: surveying battlefield religious needs, identifying units needing religious support, preparing for religious services, identifying ecclesiastical requirements and items, safeguarding privileged communication, and surveying the ethnic, cultural, and denominational religious needs of a unit.

Chaplain assistants support the UMT's pastoral ministry. They respond to distressed individuals requiring pastoral care. They both perform peer ministry and train other soldiers to provide it. They may pray with soldiers. They report specific pastoral care needs which they identify in conversations with others to the chaplain.

Chaplain assistants may assist the chaplain to assess religious needs during mass casualties. They may assess the religious needs of casualties being admitted to hospitals. They are often the "eyes and ears" of chaplains.

Chaplain assistants survey unit morale. They actively listen to others. They may help determine suicidal, homicidal, and other destructive tendencies.

Chaplain assistants provide specific MOS related administrative support which includes: coordinating religious activities in combat/field conditions, preparing and maintaining a roster of referral agencies, preparing publicity materials, and receiving, screening, and referring prospective religious counselees.

Chaplain assistants provide UMT input to the Command Operating Budget. They prepare appropriated fund purchase orders. If there are Chaplain Funds on the battlefield, they safeguard offerings and assist in managing these funds.

Chaplain assistants provide security for field services of worship, for chaplain section facilities, and for the UMT during movements. They provide or arrange for transportation for the UMT.

Preserving UMTs as teams is essential, as this permits chaplains freedom to minister at the points of greatest need. Chaplain assistants analyze religious support requirements. Chaplain assistants in mid-high intensity conflicts can provide staff and religious support during times when chaplains are involved elsewhere.

As combat organizations become increasingly austere, chaplains are increasingly becoming an extremely limited resource. As requirements for religious support on battlefields increase as the intensity of battles increase, chaplain assistants will increasingly have expanded roles. The Army must therefore preserve the Unit Ministry Team as a team if casualties are to receive essential and required religious support.

CHAPTER VIII

MANPOWER CRITERIA

The basic Chaplain Manpower Authorization Requirement Criteria (MARC), according to AR 570-2, para. 10-1, April, 1986, is fourfold:

1) One Unit Ministry Team per 700 soldiers
2) One Unit Ministry Team per major fraction thereof
3) Dispersion on the battlefield
4) Mission on the battlefield

These requirements do not include chaplain positions for hospitals and convalescent centers, which are as follows:

- Hospital less than 100 beds - 1 chaplain position
- Hospital 100 - 499 beds - 2 chaplain positions
- Field Hospital - 500 - 999 beds - 3 chaplain positions
- Hospital over 1000 beds - 3 Chaplain positions plus 1 for each 500 beds or MFCT
- Convalescent Center - 1500 beds - 3 chaplain positions

According to AR 570-2, para. 10-7 b, one chaplain assistant position is required for each chaplain position and listed in the TOE as the Unit Ministry Team (UMT) section.

General Maxwell T. Thurman, Vice Chief of Staff, U.S. Army, most recently accepted these criteria at the Personnel Service Support, Combat Service Support Systems Program Review, 11-12 June 1986, at Fort Benjamin Harrison, Indiana.

This basic UMT MARC provides minimal religious support for casualties in Echelon I. Support is minimal because UMTs organic to maneuver units cannot provide religious support at all points of wounding or all casualty collection points. The threat will constrain movements to points of wounding in mid-high intensity conflicts.

As HSSALB doctrine projects more than one treatment location in Echelon I, commanders cannot preposition UMTs at a single battalion aid station. Prepositioning also limits religious support to noncasualties.

Brigade or task force UMTs cannot augment far forward religious support to casualties. They will be coordinating religious support to casualties evacuated from forward areas. They task organize area religious coverage in mass casualty situations. They also fulfill other supervisory and staff

functions for their entire brigade. Division UMTs serve similar functions in divisions.

Casualties will receive distinctive religious group ministrations only as chaplains from their own particular religious groups are available within Echelons I and II.

Soldiers in Echelon I receive specific religious group ministrations, such as: the Roman Catholic Viaticum, the Eastern Orthodox Holy Unction, or Anointing, only if chaplains representing these groups are serving Echelon I units. Even if division commanders were to designate that chaplains from these groups provide area religious coverage, the threat would constrain their movement over broad frontages in Echelon I.

Soldiers will most likely receive distinctive religious group ministrations first in Echelons II or III, depending upon the availability of representatives of different religious groups and their capabilities to move around on the battlefield.

Current manpower availability limits Roman Catholic coverage to three Roman Catholic chaplains per division. These chaplains may provide Roman Catholic ministrations to casualties at division clearing stations. Or they may move among various casualty collection points in the evacuation stream. They also are responsible for providing Roman Catholic sacraments and other religious support to noncasualties within the division.

Current manpower availability limits Eastern Orthodox coverage to one Eastern Orthodox chaplain per corps. These chaplains will most likely provide religious ministrations first for Eastern Orthodox casualties in the corps area, although they may also be deployed forward.

Soldiers receive specific Protestant religious group ministrations only as chaplains from their particular groups are available within divisions. Division chaplains can coordinate area coverage as the tactical situation permits. Assigning as great of a mix of Protestant chaplains as possible to divisions increases the likelihood of soldiers receiving ministrations from chaplains of their own particular groups.

TAA 93 projects admitting 114,048 casualties from a 20 (19) division NATO force to Echelon III medical facilities during the first thirty days. This is approximately 5,702 casualties per division force equivalent (DFE) or an average of 190 casualties per DFE per day.

Since approximately 66% of all casualties receive treatment in Echelons I and II and return to duty, this number represents only 33% of all casualties. Therefore as many as 342,144 soldiers may become casualties. This is approximately 17,107 per division or an average of 570 casualties per division per day.

Approximately 38,776 casualties or 17% of those casualties not admitted to Echelon III medical facilities will die. This is approximately 1,939 per division or an average of 65 deaths per division force equivalent per day.

Using these projections, manpower seems adequate, but is also austere and includes a degree of risk. If divisions have an average of 24 UMTs, each maneuver unit UMT would provide religious support to approximately 24 casualties per day. This projection includes a daily average of 3 deaths and 8 casualties seriously enough wounded for them to be evacuated to Echelon III. Due to threat factors or rapid evacuation, some of these casualties may not receive religious support from UMTs organic to their units prior to evacuation.

Manpower is inadequate when threat factors, dispersion on the battlefield, or mission requirements limit religious support. Threat factors and dispersion may limit capabilities to locate casualties, move to their location, and provide religious coverage to all casualties. Mission requirements may affect the UMT's priorities or availability.

Assigning UMTs to battalion and brigade size units using a MARC of 1/700 or major fraction thereof is therefore the absolute minimum number required to provide religious support to casualties. Combat developers must also consider dispersion and mission when planning for religious support.

Basing Echelon III medical facility manpower criteria for religious support upon the number of beds occupied, as in the past, is an inadequate way of establishing hospital UMT manpower requirements. Different patients require different kinds of religious support. The time required for religious support varies as patient conditions vary. The number and mix of patients also affects manpower requirements.

A better way is to relate requirements for religious support to patient conditions. Certain types of patient conditions require certain types of religious support. Each ministry takes a different time to provide. Patients with some patient conditions require more pastoral visits than do others. However, all patients require a ministry of presence.

One way force structure planners may determine an adequate chaplain force structure is to base it upon patient admission projections for each medical facility.

For an example, they could first multiply the time it takes for each ministry by the number of patients receiving that ministry by the number of times each patient receives it. This yields the number of manhours. They then could divide this number by the number of available hours in each day to provide direct religious support to patients for each member of the UMT. This yields the number of required UMTs for the medical facility.

Since requirements are related to spiritual conditions rather than medical conditions, ministries relate to certain categories of patients rather than to specific patient conditions.

These categories include: the dying, those with life threatening conditions, amputees, those with burns, battle fatigue casualties, those with permanent or temporary disabilities, those requiring surgery, those expected to require long term hospitalization, and neuropsychiatric casualties.

The goal of religious support is to impact positively upon healing, stabilization, rapid recovery, and return to duty. Ministries provided to casualties include: a ministry of presence, ministry to the dying, a ministry of sustaining, sacramental ministry, crisis and stress ministry, ministry of guiding, ministry of worship, and ministry of celebration.

UMTs provide a ministry of presence to all casualties. If they provide it once to 114,048 casualties for 3 minutes each, a brief contact, this ministry requires 5,702 man hours.

If UMTs provide a ministry to the dying twice for 15 minutes each occasion to all "expectant" casualties and once for 10 minutes each to 50% Of all casualties with life threatening conditions, this ministry requires 2,201 manhours.

If UMTs visit each casualty requiring surgery for five minutes prior to surgery, this ministry requires 3,553 man hours.

Extrapolating in this manner from TAA 93 projections, providing essential religious support to casualties in Echelon III medical treatment facilities requires approximately 32,240 man hours for a 20 division NATO force during the first 30 days (See Figure 1).

Dividing this number by 30 days, and further dividing it by 9 available hours per day per chaplain and 5 available hours per day per chaplain assistant, yields a minimum manpower requirement of 77 UMTs, if each UMT in Echelon III medical facilities has one chaplain and one chaplain assistant.

This assumes that chaplains and chaplain assistants will work 12 hour days. It further assumes that chaplains provide essential religious support other than direct services to patients for 3 hours per day. This includes: ministry to staff, administrative functions, professional development, staff functions, and other unit and mission support.

The primary function of the chaplain assistant is to support religious activities in the medical facility. This includes providing some direct religious support to patients for approximately five hours per day. They survey religious needs, distribute religious literature, respond to distressed individuals, pray with casualties, and may assist in comforting the wounded in mass casualty situations.

Chaplain assistants also provide nondirect religious support. They coordinate religious activities, prepare for religious services, identify ecclesiastical requirements and items, coordinate religious coverage from other area UMTs, maintain data on ministries provided, and maintain appropriated and nonappropriated fund accounts.

Chaplain assistants also provide security for services, chaplain section facilities, and for the UMT during movements. They participate in all unit training. And they support other unit mission essential requirements.

Since the number of Echelon III medical facilities required nor their size have not been established as of this writing, it is not possible to match this UMT requirement with the number of hospitals. However, projections are that there will be between 49 and 59 Echelon III medical treatment facilities, including some MASH type hospitals.

Based upon projections, each hospital requires two chaplains and no less than one chaplain assistant. Since a UMT may be any combination of chaplains and chaplain assistants, the number of chaplains and chaplain assistants may not be equal.

Assigning two chaplain assistants and only one chaplain to each medical facility is possible only by expanding the chaplain assistant's function to include providing chaplain-type direct pastoral ministry to patients. This would require extensive training which far exceeds chaplain corps resources.

Ideally, each medical treatment facility would have one Protestant and one Roman Catholic chaplain, in order to maximize distinctive religious group ministries. Between 98 and 118 chaplains would then be required in support of Echelon III religious support to casualties. Holding area coverage adds a requirement of approximately ten Unit Ministry Teams.

Using the same method and projecting that there will be 33 Echelon IV medical treatment facilities, these facilities require an absolute minimum of 66 chaplains or 2 per hospital. (See Figure 2).

Religious support chaplain manpower requirements total at least 174 chaplains, or as many as 194 chaplains, to support Echelon III and IV medical treatment facilities. This is a major commitment of UMT resources.

The Army has approved a FY 87 MARC study plan of hospital ministry requirements. My recommendation is that this study attend closely to relating religious support to patient classifications. It should also clearly describe soldier tasks in providing religious support to casualties. Adapting general religious support tasks to religious support to casualty tasks does a disservice to the complexity and depth of this ministry.

Echelon III

Ministries Provided Data

Ministries	Tot Pat Adm	Mean/Day	Mean/Beds	X	%	Min	Total Hr
Presence	114,048(100%)	3801.6	14,119.2	1	100	3	5,702
Needs Assess	114,048(100%)	3801.6	14,119.2	1	100	5	9,504
Dying	780(.6%)	26.0	84.7	2	100	15	390
Life Threat	20,535(18%)	648.5	2,541.5	1	50	10	(1,711)
Sustaining							
Amputees	7,346(6.4%)	249.9	903.6	1	100	10	123
Burns	4,272(3.7%)	142.4	522.4	2	100	10	1,424
Perm Disab	20,649(18.1%)	687.3	2,555.5	1	50	10	(1,721)
Hosp 90+Days	30,680(39.1%)	1022.6	5,520.5	1	50	10	2,557
Sacramental	114,048(100%)	3801.6	14,119.2	1	10	15	2,851
Crisis/Stress							
Stress/Fat	3,540(3.1%)	118.0	437.7	1	100	15	885
Psych	8,268(7.4%)	275.6	1,044.8	1	50	10	689
Sev Burns	2,339(2.1%)	78.0	296.5	2	100	10	(780)
Pre Surg	85,267(74.8%)	2842.2	18,875.9	1	50	5	3,553
MFW	29,306(25.7%)	976.9	3,628.6	1	50	10	(2,442)
Guiding	114,048(100%)	3801.6	14,119.2	1	10	15	2,851
Worship	114,048(100%)	3801.6	14,119.2	1	10	4	(760)
Ambulatory	57,094(50%)	1900.8	7,059.6	1	20	4	761
RTD	30,494(26.7%)	1016.5	3,769.8	1	20	4	(407)
Non RTD	26,600(23.3%)	866.7	3,289.7	1	20	4	(354)
Non Ambul	56,954(50%)	1900.8	7,059.6	1	5	10	475
Celebration	114,048(100%)	3801.6	14,119.2	1	5	5	475
TOTAL							32,240

(Number of hours in parentheses not included in total)

FIGURE 1

Figure 1 (cont)

Noted overlaps in religious coverage identified above include:

Life Theatening Conditions	-(1,711) Hours	50%
Amputees	- 123	
Burns	- 1,424	
Permanent Disability	-(1,721)	50%
Hospitalized 90+ Days	- 2,557	50%
Severe Burns	- (780)	
Pre-Surgery	- 3,553	50%
MFW	-(2,442)	50%
Guiding	- 2,851	10%
Celebration	- 475	5%

These overlaps are accounted for by lowering the percentages for ministries provided for some categories. A specific patient could therefore receive ministry in more than one category and more than one time, in addition to having religious needs assessed.

Since Permanent Disability and Hospitalized 90+ days significantly overlap, as do Pre-Surgery and MFW, only the higher number of hours of the two has been included in the total number of hours. Since Life Threatening Conditions and Severe Burns are 100% included in other categories, these are not counted in the total number of hours.

Echelon IV

Ministries Provided Data

Ministries	Tot Pat Adm	Mean/Beds	X	%	Min	Total Hr
Presence	87,023	10,904.83	1	100	3	4,351
Needs Assess	87,023	10,904.83	1	100	5	7,252
Dying	23	7.01	3	100	15	17
Sustaining Guiding Crisis/Stress	87,023	10,904.83	1	100	10	14,504
Sacramental	87,023	10,904.83	1	10	15	2,176
Worship	87,023	10,904.83	1	10	4	(580)
Ambulatory	58,361	7,306.23	1	20	4	778
Celebration	87,023	10,904.83	1	10	5	725
TOTAL						29,803

(Number of hours in parentheses not included in total)

FIGURE 2

CHAPTER IX

RELIGIOUS SUPPORT TRAINING REQUIREMENTS

The Army cannot assume that either civilian education or military training has prepared chaplains and chaplain assistants for the stresses, the horrors, the trauma, and the suffering that they will experience on the modern integrated battlefield.

Training in field environments for Unit Ministry Teams today seldom includes training in religious support to casualties, even when UMTs do perform casualty play with aid stations.[1] Training seldom exposes UMTs to "casualties" prepared for treatment using the moulage techniques that are so much a part of training medical teams in mass casualty exercises.

Chaplain Emory Cowan, an experienced combat, hospital, and hospital ministry training chaplain, writes:

> We should not be deluded into thinking that ministry to troops in the field is analogous to ministry to troops in combat. The issues are not the same. The presence of mutilated bodies, the smell of burnt flesh, confrontation with hollow-eyed, disoriented troops, and the fleeting awareness that one's own life could be terminated, make the field exercise seem like a church picnic.[2]

Chaplain Cowan also points out that collective combat experience in the chaplain branch is rapidly diminishing. Many chaplains who served in Vietnam have now retired.[3] Relatively few chaplains now on active duty have experienced the highly lethal environment and the mass casualties of a modern battlefield.

Some chaplains who were in Vietnam or Granada did not come into direct contact with battlefield casualties. Younger chaplains, who are most likely to be forward on the battlefield, are those who most lack experience. Only a few have prior military combat experience or have participated in mass casualties in civilian life.

Neither can the Army assume that chaplains' civilian education has prepared them for combat ministry to casualties. No civilian theological seminary or school is known to offer a course in combat ministry.

Most seminaries and schools do, however, offer courses in hospital ministry which discuss trauma ministry. Some of these courses include experiential learning in a medical treatment facility.

Many seminaries do require one quarter of Clinical Pastoral Education. This is an experiential learning process which exposes participants to "living human documents," often within a hospital setting. Some ministers, however, receive this training in nonhospital settings, such as: a counseling center, a parish, or a prison. These programs do not expose participants to medical trauma.

No military chaplain or civilian theologian has ever suggested that we can competely prepare ministers or anyone else for what they will experience on the battlefield.

In the aftermath of the San Diego airplane crash on 25 September 1978, Dr. Alan Davidson, a clinical and forensic psychologist, discovered that many attending veteran police officers had disabling post-traumatic stress reactions following the disaster.[4] However, this does not preclude establishing training programs which will lesson the effects of battlefield trauma and assist UMTs to prepare for ministry to casualties.

Military chaplains have established several training programs. They have suggested others.

Chaplains Alcuin Greenberg, Al Delossa, and Emory Cowan established one of the first, a one day orientation to hospital ministry, at Fort Ord, California, in 1978. One of the objectives was to increase participants', all first-term chaplains, capacities to cope with the trauma of battle by requiring them to witness a surgical procedure. Eight of the twelve participants felt faint or nauseated. Some left the operating room. One refused to participate.[5]

One of the training needs is for desensitization training. One chaplain told this writer that he feels faint and gets sick whenever he enters a hospital. A chaplain cannot provide selfless ministry to casualties in this condition.

Responding to this need and as a result of his previous experience, Chaplain Cowan developed a two week course in September, 1979, entitled "Trauma and Survival," at Brooke Army Medical Center at Fort Sam Houston, Texas. His goal was to assist chaplains to draw on some basic resources that would aid them in surviving spiritually and emotionally in the presence of trauma. The three stated objectives were:

1) To prepare the chaplain affectively and cognitively for ministry in combat and mass casualty situations.
2) To help the chaplain focus and clarify his own responses to trauma and high stress.
3) To assist the chaplain to discover means within himself to cope with trauma and to continue to function as a representative of God.[6]

Learning settings included the Institute for Surgical Research (the hospital burn unit), Surgery, Anatomical Pathology, and the Emergency Room.

These settings not only introduced participants to medical procedures in which they would see and smell blood, patients burned beyond recognition, and both live and dead bodies receiving surgical treatment, but also confronted them with their own finitude. Participants then discussed their experiences, thoughts, and feeling responses in small support groups.[7]

This program produced many positive results. Participants discovered personal and spiritual resources for coping with trauma. Others discovered new meaning for their lives and ministries and new understanding of their relationship with God. Some discovered that they needed to vent their anger, share their fears, hurts, and frustrations, and unconditionally accept one another. Several identified it as an experience of grace and healing. The experience challenged their faith, supporting belief systems, and values.[8]

Chaplain Jay Ellens, the editor in chief of the Journal of Psychology and Christianity and the Executive Director of the Christian Association for Psychological Studies International, has proposed four key areas in which to prepare chaplains if they are to minister effectively in combat.[9]

First, he stresses the importance of spiritual preparation. Noting that many of the hundreds of chaplains to whom he has spoken have "extremely superficial" rationales and philosophical systems for "holding up" in mass casualty situations, he writes:

> Most do not really comprehend what an experience of that extremity will be like in actual fact and have extremely simplistic notions of what a theological world-view really is, what a coherent and comprehensive ethical system really is, and what the crucial importance of both are for making sense in the potential holocaust we face.[10]

Chaplains must be able to maintain wholeness, hope, meaningfulness in ministry, trust, fervency, and assurance of God's unconditional grace to survive in the face of trauma.

Second, Chaplain Ellens stresses the importance theological preparedness or having:

> ...a profound and carefully worked out theological world view in which mobilization, war, mass casualties, and NBC environments involving masses of civilians as well as soldiers can be accounted for satisfactorily, and and coherently explained, experienced, and integrated smoothly into meaningful thought and feeling. That will be possible only if the chaplains are trained to be relatively sophisticated in theological concepts and faith insights. Only in a theological world-view which affords meaning to human suffering, inhumaneness, and irrationality, in a way that neither jeopardizes the integrity of God in his grace nor further demeans suffering humans by assigning some sort of equivalency or cause and

> effect relationship between our guilt and our pain, will chaplains find a sufficiently durable faith perspective as to survive mobilization and war without hopelessness, depression, or psychotic breakdown.[11]

Third, Chaplain Ellens stresses the importance of ethical preparedness. Chaplains must embrace as an ethical imperative their being wherever there are suffering people in need, regardless of whether or not the cause seems ethical to them.[12]

Chaplain Ellens views war as always immoral and as the lesser of two monstrous evils to which responsible people are sometimes driven.[13] The ultimate pastoral question is what chaplains should do with wars in responsibility and godliness. He concludes that chaplains must be there to minister to those who are suffering.[14]

Fourth, Chaplain Ellens stresses the importance of psychological preparedness. The goal is to have stable, resilient, and concerned chaplains who understand themselves, who can respond to and with feelings, who can creatively manage anger, anxiety, stress, and depression, and who can provide mutual support to other chaplains as colleagues.[15]

In conclusion, Chaplain Ellens reiterates the importance of adequate theological world-views, spiritual rationales, ethical perspectives, and psychological stability to "get through" the combat experience. He suggests that chaplains can be more than rescuers of the miserable. They can also be ethical guides in constructing a moral universe in the midst of a seemingly immoral environment. They can assist in building the Kingdom of God.[16]

Chaplain Douglas Larson, a Navy chaplain, in an unpublished paper dated 31 May 1985, suggested a program for combat training of Navy chaplains. His suggestions are based upon his experience of a one day training event on 14 March 1984.

This program introduced participants to some of the frightful aspects of combat ministry to casualties through the use of vivid photographic slides. It included presentations on the types of medical combat casualties, the types of psychiatric casualties, the health care team, ethical dilemmas and triage, techniques for ministry in combat medicine, and the function of the chaplain in combat.

Whereas this seminar introduced the issues, Chaplain Lawson evaluated it as lacking opportunities for "hands on" training, role play, and sufficient discussion.[17]

Chaplain Lawson suggests a course similar to the Brooke Army Medical Center program, "Trauma and Survival." He suggests training chaplains in medical treatment facilities that have large numbers of trauma patients, including a burn ward. Recent experience in the Navy in which there have been several serious fires on board ship to which chaplains have responded make training in ministry to burn patients essential.

As an alternative, he suggests expanded one day training events. Or the Naval Chaplain School could provide more training in combat ministry to casualties. Or chaplains could be assigned to emergency rooms of hospitals in Providence, RI, or Boston, MA, as part of their training.

Chaplain Lawson concludes, "While nothing short of the actual event approximates the combat experience, it is possible to at least rehearse for the battlefield environment."[18]

Each of these programs or proposals identifies a need for experiential training in combat ministry to casualties. The existence of more than 500 Clinical Pastoral Education programs conducted in hospitals and medical centers is further verification that many civilian clergy and their teachers recognize the importance of pastoral training in a trauma center.

The Chaplain branch can also give more attention to training Unit Ministry Teams in field environments, using realistic training aids, and encouraging UMTs to be involved in casualty play at aid stations. UMTs can respond "as if" they were in combat, as others do.

Chaplain (MG-Ret) Patrick J. Hessian, in a letter to all Army chaplains, dated 1 September 1985, when he was Army Chief of Chaplains, wrote:

> I feel very strongly that when chaplains go to the field with their units, they must be concerned with much more than a "ministry of presence", or simply "talking with soldiers," demonstrating a willingness to share hardship or conducting religious services. They must prepare and train the Unit Ministry Teams (UMT) to carry out the entire program of ministry in a hostile, fierce combat environment.[19]

There has been some progress in training UMTs for combat ministry. FC 16-51 suggests that Unit Ministry Teams have a larger role in treating battle fatigue casualties. The National Training Center, Fort Irwin, Ca., is now developing standardixed UMT training. And in July, 1985, the U.S. Army Soldier Support Center fielded a new ARTEP Personnel Service Support Common Module, in which Chapter 7 describes the mission of the battalion chaplain.

Approximately 15% of all Army chaplains or 10-12 chaplains per year do receive Clinical Pastoral Education in medical treatment facilities, usually in their 6th to 9th year of military service. Since this training qualifies them for validated hospital ministry positions, most have follow-on assignments in military hospitals.

Training so few chaplains specifically in trauma ministry and/or in trauma settings is a deficiency. The Chaplain Corps must correct this deficiency if UMTs are to provide the best possible religious support and the ministries described in this study.

Many of these training requirements are also applicable to chaplain assistants. As fighting forces become increasingly more austere, chaplain assistants will become increasingly involved in providing direct religious support to casualties.

One division chaplain, responding to the question of how chaplain assistants can be used in casualty care, forthrightly declared that the chaplain assistant is not in the casualty care business.

Other division chaplains foresee using chaplain assistants to support the chaplain, screen casualties for the chaplains, list priorities, identify critical casualties, provide stress management, be a medic, conduct triage, be a casualty monitor, and identify and locate casualties. Thus nine out of ten division chaplains who responded to the survey foresee chaplain assistants as providing religious support to casualties.

Within constraints chaplain assistants can provide valuable lay religious support to casualties, especially if they are trained and supervised, and they coordinate their support with chaplains. The Army cannot expect them to have the same counseling skills or theological sophistication that chaplains do. Nor does the Army have sufficient resources to train them as chaplains or to have chaplain-like skills.

One of the most valuable functions for which the Army can train chaplain assistants to do is the religious needs assessment of patients being admitted. Performing this "religious triage" frees the chaplain to provide religious support where it is most needed and helps ensure that all casualties receive religious coverage.

In order for chaplain assistants to serve this function, most will require some training to prepare them to cope with the sights and smells of battlefield injuires. They will be meeting casualties in triage areas. They will see death, mutilated bodies, open wounds, blood, massive burns, amputations, emergency surgical procedures, and many of the horrors of battle.

The Army can also train chaplain assistants to provide a ministry of sustaining. Lay persons have traditionally provided this ministry. They can stay with the dying so they are not alone, can provide acceptance for those with permanent disabilities, and be someone with whom to share the silence for those who are suffering.

Since someone being there is often more important than what is said or done, they need only an understanding of the value of this ministry and the ability to cope with their own intruding feelings in order to provide this ministry. Sharing this ministry with chaplains, chaplain assistants free chaplains to be with others who need other described ministries.

The Army does train chaplain assistants to support religious services and perform the administrative duties that are essential to religious coverage. The Army can train them to keep accurate records of ministries provided to support manpower requirements.

The Army can also train chaplain assistants in listening skills, crisis intervention, and to provide small group studies. Chaplain assistant Soldier's Manuals list many more functions for which the Army trains chaplain assistants. Many of these functions are essential to providing religious support to casualties.

The Army trains fifteen to twenty chaplain assistants each year during a one week program at Brooke Army Medical Center, Fort Sam Houston, TX, to provide direct religious support to patients. Ward visitation and exposure to trauma are integral parts of this program.

Some have suggested training Unit Ministry Teams together. Whereas some chaplains think that training chaplains and chaplain assistants together would blur functional distinctions between chaplains and chaplain assistants and interfere with supervision, others think team training would increase overall effectiveness. As UMTs train together, they would discover each other's talents as well as each other's needs. They would learn to trust one another.

Whereas this usually happens over a period of time as members of a team work together, placing them in the crucible of trauma settings would speed the process of their realizing their potential as a team.

Depending upon the personalities and perspectives of those participating in this training, team training could work. This proposal deserves both further study and experimentation.

CHAPTER X

CONCLUSIONS

Neither health service support nor Chaplain Corps doctrine adequately describes religious support to casualties. Nor do medical personnel or Unit Ministry Teams receive enough training in religious support to casualties for them to understand it. They lack ability to provide for religious support that maximizes healing, stabilization, rapid recovery, and return to duty.

Unit Ministry Team doctrine contains few references to religious support to casualties. Even though FM 16-5 states that ministry to casualties is the highest priority during battle and post battle phases of combat on the AirLand battlefield, FM 16-5 devotes less than two pages to discussing religious support to casualties.

FC 16-51, a newly published field circular, does describe in depth battle fatigue ministry. It references some of the spiritual bases for religious support. It also includes task lists for both chaplains and chaplain assistants.

Health service support doctrine includes no references to religious support. However, TOE documents do briefly describe chaplain and chaplain assistant duties.

Threat factors on the AirLand battlefield will make it difficult for UMTs to provide religious support to all soldiers on the battlefield. UMTs will have difficulty locating both units and soldiers. Commanders will widely disperse soldiers. UMTs will have difficulty moving across the battlefield to where soldiers are. NBC environments make this even more difficult.

UMTs will have similar difficulty locating casualties. There may be several casualty collection and medical treatment locations in Echelon I health service support. Threat factors may impair communication. Threat factors will also constrain or impede movement to casualty collection and treatment locations.

Prepositioning UMTs is not the answer. It would constrain religious support to noncasualties. It would limit support to casualties at points of greatest need. UMTs must be free to move as the tactical situation permits among many different locations.

The potential for mass casualties has never been greater. The lethality of modern weapons, massive concentrations of forces and fires, and attacks upon all echelons simultaneously will contribute to all units experiencing casualties, not only far forward units. UMTs in rear areas must prepare for mass casualties, particularly if NBC weapons are employed or if friendly forces do not have substantial air superiority.

Fighting on an integrated battlefield will produce many combat stress reaction casualties in all echelons. UMTs have a role both in preventing and treating battle fatigue.

As there will be few "safe" areas for rest, recuperation, and reconstitution, spiritual health which sustains soldiers in combat and when they become casualties is important to soldiers' total well-being.

The potential for UMTs becoming casualties has also never been greater. Forward Thrust doctrine places UMTs far forward with the troops on the AirLand battlefield and exposes them to the same risks. UMTs may become isolated as fronts are ill-defined, particularly if they move independently on the battlefield.

UMTs must apply tactical considerations in all their actions. Their moving with others, when possible in convoys at night with night vision devices, lessens their risks of becoming casualties.

UMTs must be proficient in common soldier skills. They must understand the battlefield and their unit's tactics and mission. They must restrict independent movements. UMTs must also maintain spiritual, psychological, and physical fitness if they are to prevent their becoming battle fatigue casualties themselves.

Commanders and soldiers expect and value religious support. Some senior commanders have stressed that spiritual health is as important as physical health or the condition of the equipment in sustaining soldiers in battle.

Commanders and soldiers also expect chaplains to be "with the troops" in combat. They specifically expect chaplains to be there to minister to the dying and others who are seriously wounded. They affirm a 200 year old tradition in which chaplains have been on the battlefield, often far forward, to care for soldiers' religious needs.

Some religious groups require specific ministrations for the dying, the sick, or the wounded. Military regulations support meeting these requirements, as long as they do not conflict with tactical missions. UMTs of particular religious groups must prepare to provide religious support to soldiers of all religious faiths. They must expect to provide specific religious group ministrations for soldiers from other units as tactical situations permit.

Medical treatment personnel also require religious support. Their education or experience has not necessarily prepared them for the chaos and brutalization of the modern battlefield. Mass casualty situations will require that they make difficult triage choices. Some may lose faith or suffer ethical dilemmas. UMTs must be there with medics to assist them in contextualizing their experiences.

The chaplain's presence on the battlefield as a symbol is important to sustaining soldiers in combat. Chaplains symbolize faith, hope, and love. They represent God and supporting communities of faith. They symbolize God's and community identification with suffering and sacrifice.

UMTs as symbols have power to influence attitudes, feelings, and behavior. Their presence can buoy spirits and strengthen morale. Merely their presence can assist healing, stabilization, and stress reduction.

UMTs best use their time and energies in providing religious support to casualties when they perform religious "triage" prior to providing specific ministries, when they briefly assess casualties' religious needs.

Chaplain assistants can assist in this assessment. They can assess casualties' religious needs, prioritize casualties for the chaplain to see, and offer reassurance by their presence as caring persons. This is most important when providing religious support in mass casualty situations.

The ministries that UMTs provide include: ministry to the dying, ministry of sustaining, sacramental ministry, crisis and stress ministry, ministry of guiding, ministry of worship, and ministry of celebration.

Each ministry addresses identified spiritual conditions that casualties often experience. These include: crises of faith, fear, grief, guilt, and despair.

These conditions are spiritual when soldiers relate them to ultimate realities, meanings, and values, relate them to faith relationships with God and others, make them the subject of theological inquiry, conceptualize them theologically using "God" language, and/or use religious resources to resolve them.

The traditional ministry of guiding has three forms: inductive, eductive, and collaborative. Guiding is much more than telling others what they should or should not do. It often draws on soldiers' own resources. It encourages decisions within their own value frameworks. It stimulates consideration of other moral and cultural factors.

The goal of the ministry of guiding is to assist others to make decisions consistent with both individual and societal values.

UMTs also provide a ministry of celebration. Soldiers do celebrate on the battlefield, even when wounded. Supporting their celebration strengthens morale and increases resolve.

Emerging health service support doctrine has implications for UMT religious support to casualties. How the health service support system organizes for combat affects religious support requirements.

First, emerging health service support doctrine proposes making extensive use of combat lifesavers. This has led some to suggest training UMTs as combat lifesavers. This suggestion is rejected.

Using UMTs as combat lifesavers would seriously dilute their ministry to soldiers. It could divert them from fulfilling their most important functions on the battlefield. However, all UMTs as soldiers should be highly proficient in first aid and expect to provide first aid that may be lifesaving.

Second, splitting the forward battalion level treatment squad into two treatment teams at two separate locations makes it impossible to preposition UMTs at a battalion aid station. UMTs must be free to move among several locations to provide religious support to both casualties and noncasualties.

Third, emerging doctrine proposes an additional medical clearing station within the brigade AO. Casualties evacuated to or through this location require religious support. Many will not have received religious support in forward areas. Brigade UMTs best provide for this coverage.

Fourth, emerging doctrine proposes establishing holding areas for casualties in the division area. Casualties in these locations require religious support. Division UMTs must provide for this coverage from either their own assets or through task organizing other UMTs in the division AO.

Fifth, emerging doctrine proposes assigning a chaplain without a chaplain assistant to each new combat stress control platoon. This adds a new requirement for a chaplain. Omitting the chaplain assistant limits religious support to battle fatigue casualties as described in FC 16-51. According to this field circular, the chaplain assistant performs many important functions in supporting battle fatigue casualties.

Sixth, emerging health service support doctrine suggests that commanders may deploy medical units at times only partially or austerely as modules.

If one or both members of the medical unit's UMT are not deployed, casualties will not receive religious support from UMTs organic to medical units. Maneuver unit UMTs in forward areas must then be prepared to provide religious support at medical treatment locations. UMTs in rear areas must be prepared to provide religious support for casualties evacuated into their areas. They cannot assume that casualties will have received support in forward areas.

Present Echelon I and II UMT organization is adequate for providing minimum religious support to casualties. As UMTs become isolated or restricted in movement, brigade level UMTs are key to maintaining both continuity for religious support to casualties in these levels and organizing religious support in the brigade area. They are also key to providing for some initial religious support for casualties evacuated from forward areas.

Echelon III and IV organization is adequate only if the Army maintains current organization and manning. Each corps level medical treatment facility requires both Roman Catholic and Protestant coverage. Assigning two chaplains to each facility also permits the around the clock coverage that mid-high intensity conflicts require.

Present organization and manning by definition is inadequate for mass casualty situations. However, planning for these contigencies is possible. Less than half of all divisions have coordinated mass casualty plans. It is important that each division and each unit have a coordinated plan if religious coverage is to be adequate.

The Chaplain branch has not adequately studied requirements for religious support to NBC casualties. A separate study is the best way to address these contingencies.

Preserving the Unit Ministry Team as a team is essential to providing religious coverage as described both in chaplain branch doctrine and this study. The chaplain assistant is an integral member of the team who provides essential religious support. The chaplain assistant is essential in accomplishing religious triage, maintaining continuity of ministry, and coordinating religious support.

Past manpower criteria are inadequate. They relate to the numbers of patient beds and not to the numbers of patients in specific patient categories or classifications. Since the focus of UMT ministry is spiritual, it is not possible to relate religious support to specific physical conditions. Religious support, however, can be related to spiritual conditions. And ministries provided can be related to categories of patients.

Chaplains must make provision for distinctive religious group and denominational ministry, particularly within Echelons III and IV. Assigning chaplains who represent less represented groups to corps level units increases the likelihood that they can provide area coverage ministry to casualties.

Echelon III and IV manpower requirements are substantial. Supporting a 20 division NATO force in a mid-high intensity conflict may require assigning as many as one out of four UMTs to Echelon III and IV medical treatment facilities.

What are the priorities for religious support in mid-high intensity conflicts? Should casualties be the highest priority? Or should returning to duty casualties be? Should noncasualties be the highest priorities? Or should there be any priority? Regardless of force structure, the Chaplain branch must continually reevaluate priorities and develop doctrine reference priorities for religious support to all soldiers on the battlefield.

Neither civilian education nor military training presently prepares UMTs for combat ministry to casualties. Many UMTs lack spiritual preparedness that will enable them to maintain wholeness, hope, meaningfulness, trust, fervency, and assurance of God's unconditional grace to survive in the face of trauma.

Many UMTs do not have theological world-views which afford meaning to human suffering, inhumaneness, and irrationality that neither jeopardizes the integrity of God in his grace nor demeans human suffering.

Many UMTs also lack ethical preparedness which will assist them to be where suffering people are, regardless of whether or not they agree ethically with policies that place them there. Many lack psychological preparedness that will enable them to maintain stability, resiliency, creativity, and concern for others.

UMTs receive the best training for combat ministry to casualties in trauma centers which expose UMTs to the stresses and trauma of caring for dying,

seriously wounded, or injured persons. Many UMTs require training which desensitizes them to blood, open wounds, burns, mutilations, and other brutal injuries.

UMTs receive the next best training in field exercises which involve casualty play. However, half of the division chaplains surveyed reported that their divisions' UMTs do not perform casualty play during field exercises. UMTs assigned to non-field or other support units that infrequently train in the field also receive limited training in caring for casualties.

The Chaplain branch can train UMTs either separately or as a team. Team training has the advantage of facilitating trust building that is essential to effective functioning. If not done properly, it may undermine supervision. However, the Chaplain branch should still consider training UMTs as teams.

The chaplain branch should continue to support training chaplains in Clinical Pastoral Education in trauma centers. They also should continue to train chaplain assistants in short course hospital ministry training.

Providing religious support to casualties is one of the most difficult ministries that UMTs will provide on the AirLand battlefield. It requires the very best in training.

CHAPTER XI

RECOMMENDATIONS

1. Expanding discussions of religious support to casualties in chaplain branch doctrine in order to reflect properly this ministry's importance.

2. Beginning discussions with Army Medical Department representatives as to how they could include more references to religious support as essential and required in future health service support doctrinal writings.

3. Affirming the Unit Ministry Team's function of providing religious support to both noncasualties and casualties as a demanding ministry, which precludes assigning any functions to the Unit Ministry Team which are not in keeping with its mission.

4. Each division and each unit having a coordinated mass casualty plan in addition to a religious support plan for each tactical operation, each field training exercise, and each garrison.

5. Including a study of religious support to NBC casualties as a part of the proposed NBC environment study.

6. Relating UMT tasks to patient classifications in all future Manpower Authorization Requirement Criteria hospital ministry studies.

7. Expanding UMT training in religious support to casualties through providing more training for Unit Ministry Teams in trauma centers, more field training in casualty play, and more local training in providing religious support to casualties.

8. Training all chaplains and chaplain assistants to provide religious support to members of religious groups other than their own, according to guidelines established by each distinctive religious group. Undertaking a separate study to determine these guidelines.

9. Developing hip pocket references in the form of a laminated card for Unit Ministry Teams to carry with them into combat which will assist them in conducting religious needs assessments, in identifying spiritual conditions, and in providing religious support to casualties.

ADMINISTRATIVE APPENDIX A

DEPARTMENT OF THE ARMY
ACADEMY OF HEALTH SCIENCES, UNITED STATES ARMY
FORT SAM HOUSTON TEXAS 78234 -6100

REPLY TO
ATTENTION OF:

HSHA-CDS

8 DEC 1984

SUBJECT: TRADOC Study Plan AR 5-5 "Chaplain Support to Casualties on the Airland Battlefield" ACN 064346

Commandant
US Army Chaplain School and Center
ATTN: DCD
Fort Monmouth, New Jersey 07703

1. PURPOSE: To examine chaplain support to casualties on the Airland battlefield in order to determine the actions needed to correct deficiencies and offer a positive contribution to the return to duty (RTD) medical mission.

2. REFERENCES: See Inclosure 1.

3. TERMS OF REFERENCE:

a. Problem. Conventional threat doctrine requires determine action and definition of chaplain support to casualties, to include, requirements, capabilities, and deficiencies on the integrated battlefield.

b. Impact of the Problem. Failure to identify and recommend alternatives to the deficiencies and limitations will result in the degradation of the operational capability of the chaplain to perform his mission of support to casualties. Failure to define the capabilities of chaplain support to casualties will have a negative impact on the soldier's concept of how he will be cared for when injured. This is significant, as this concept is an enabler in the motivation of the soldier's will to resist the enemy. Chaplain support impacts on the soldier's morale and his combat effectiveness as a fighting force. Inability to provide chaplain support to the casualty detracts from the fighting capability of the soldier and his leaders. The moral and ethical decisions will overwhelm the living when lack of foresight and preparation have prevented the living to care for the wounded and dying. This is a morale, psychological, and spiritual "force multiplier" for the commander.

c. Objectives.

(1) To assess the problem systemically in order to draw objective analytical conclusions on chaplain support to casualties.

(2) To assess chaplain support in doctrine and training by the proponent branch and in current and emerging medical doctrine.

(3) To assess the role and function of chaplain support to the casualty.

(4) To determine the scope of chaplain support requirements for the broad spectrum of casualty care from point of wounding to hospitalization.

(5) To identify and prioritize chaplain capabilities for casualty support.

(6) To assess the chaplain support requirements to TOE casualty care units without organic, internal chaplain capabilities.

(7) To identify religious issues being asked by chaplains and commanders confronted with the Airland environment, congruent with the reality of the integrated battlefield, as these issues impact upon casualty care.

(8) To evaluate role and function of chaplain assistant as member of UMT in the pastoral care of casualties, e.g., support to "Battle Stress" casualties.

(9) To identify changes in doctrine, organization, operational concepts (O&O), and in training to overcome deficiencies.

d. Scope.

(1) This study will consider chaplain support to casualties at echelons at Corps and below with a theater slice, to casualties from point of wounding through medical system.

(2) This study will recommend doctrinal areas for the Chaplain Branch impacting upon care and ministry in support of casualties on the integrated battlefield within the Airland environment.

(3) This study considers the terms chaplain and UMT (unit ministry team) as synonymous and interchangeable.

e. Limitations.

(1) This study is limited to battlefield environment.

(2) This study is conducted in the context of the European scenario of the threat of Airland Battle.

f. Assumptions.

(1) Forward Thrust doctrine will be implemented in the 1990's in the J and J420 TOE series.

(2) The individual soldier has religious needs over and above demoninational requirements.

(3) Pastoral care by chaplains to casualties has a positive affect upon the wellness of and rapid RTD of casualties.

(4) The presence of a chaplain with the casualty is a morale multiplier for the unit in combat.

(5) The chaplain is a "combat" person, in the same manner as the medic.

(6) The chaplain is a member of the medical team providing health care. A spiritual model for ministry to casualties is subsumed as integral to a medical model for healing.

(7) The chaplain is a role model and father figure to soldiers in demonstrating positive approaches in dealing with pain, suffering, grief, and death.

(8) It is assumed that questions/issues raised by 3c(7) may be better addressed in a separate study.

g. Essential Elements of Analysis (EEA).

(1) What is the definition of casualty?

(2) What is the UMT function in support to casualties?

(3) What functions are considered essential chaplain support to casualties by religious groups?

(4) What is the soldier expection of chaplain support to the casualty?

(5) Where will the chaplain be located organizationally in the medical support chain to provide pastoral care to casualties?

(6) What moral, ethical, and societal value factors contribute to an enhancement or a degradation of espirit in the care of casualties in their RTD?

(7) What pastoral care actions contribute to the rapid RTD of casualties?

(8) What are the expectations of commanders of the UMT in assisting in the care of casualties?

(9) What is the relationship between the ratio of battle stress to WIA casualties and the utilization of the chaplain in providing pastoral care in the medical model?

(10) What chaplains should have training in psychology to provide pastoral care to BSI?

(11) What chaplains should have training in ATLS (advanced trauma life saving support) in order to provide support to casualties?

(12) What is the preventive role of chaplains in the management and treatment of stress casualties?

(13) What is the role of laity in assisting the UMT in providing support to casualties?

(14) What level of proficiency should the UMT have in first aid to provide effective support to casualties?

(15) How does the deployment of medical units impact upon the chaplain's capability to support casualty care?

(16) What are the capabilities of and requirements for chaplain support to casualties during the phases of battle on the integrated battlefield?

(17) What are the constraints of the integrated battlefield/environment upon the chaplain's capability to provide support to casualties?

(18) What is the chaplain's capability to provide support to mass casualties?

(19) How does the categories of battlefield casualties impact on the ministry requirements to those same casualties?

(20) What is the scope of chaplain support requirements for the RTD, minimal care facilities, NBC casualties, and casualty evacuation?

(21) What is the chaplain's function in providing support to minimal care battalions for patients triaged as expectant?

(22) What resources does the concept of "volunteerism" offer in the context of augmenting chaplain support to casualties as a practical application of lay participation?

(23) How can the chaplain provide support to both individual and unit target groups in the provisions of casualty care?

(24) What is the ability of the chaplain UMT to transcend the personal fear of survival and sustain support of casualties.

(25) What is the ministry to the health care providers under the battlefield scenario?

(26) What yardstick is indicated for manpower requirements in providing chaplains to casualties?

h. Constraints.

(1) The opportunity for chaplain play and casualty play in FTX's or simulation is limited.

(2) Real world experience for mass casualty and NBC ministry is limited.

i. Operational Concept. This study measures the capacity of the Unit Ministries Team (UMT) to provide spiritual support and pastoral care to the wounded in action (WIA) and Non-Battle and Disease Injuries (NBDI). The "austere, but adequate" medical concept, along with the chaplain manpower constraints and the emphasis upon sustained operational capabilities test the resources of existing systems, human and organizational. The consequence of employing weapons, chemical and nuclear, on combat and support elements and such medical support tasks as triage and evacuation, will create never before dealt with ethical and moral issues for chaplains and commanders. These same consequences affront the sensibilities of American character and create a serious psychological and moral challenge to our combat force effectiveness. Pastoral care is ministered on the basis of a chaplain triage, utilizing the chaplain assistant as a triage manager, to provide support to the most serious first, the reverse of combat medical treatment. The vulnerability of the wounded requires the strength of the individual soldier's faith for comfort and solace. The chaplain provides the command a resource in the management of RTD battle stress casualties and maintaining unit combat effectiveness. Chaplain support is provided as far forward as possible to the wounded and dying in agreement with the forward thrust doctrine. The chaplain will encounter the reality that not all WIA will receive medical treatment. The chaplain presence represents the symbolism to the soldier that the nation and God care for the welfare of the wounded soldier.

j. Measures of Effectiveness: (MOE)

(1) The analysis of training the UMT will have had to function on the integrated battlefield.

(2) A comparative analysis of area deployment of UMT to determine if chaplains have access to casualties in order to provide religious coverage.

k. Methodology.

(1) A consideration of threat implications against religious system through threat analysis.

(2) Analysis of medical support to casualty.

(3) Analysis of patient densities in context of battle scenario.

(4) Analysis of types of injuries and acuity of care from the computer generated clinical data base in the context of scenarios developing casualties from hostile contact for evaluation of chaplain deployment to appropriate response to casualty generation.

(5) Discussion of medical philosophy treatment modalities to the casualty.

(6) Analysis of chaplain deployment to the casualty management system, to include the theater slice.

(7) Evaluation of MAA identified deficiencies and the testing of the validity of deficiencies and capabilities as derived by professional judgement.

(8) To utilize data from war/modeling, field tests, field exercises to provide objective analysis of deficiencies and to determine alternative solutions.

(9) Survey of each major faith group for definition of chaplain support requirements to the casualty.

(10) Utilization of analytic techniques to include survey, sampling, questionnaire, professional judgements, field evaluations, role play, statistical analysis and appraisal of scenarios resulting from combat and casualty experience.

(11) Preparation of prioritized list of chaplain MAA deficiencies in support of casualties.

(12) Preparation of prioritized list of preferred solutions with recommended actions to implement same.

1. Related Studies.

(1) ACN 044666 Chaplain Support to the Manuever Battalion.

(2) ACN 036882 Battlefield Religious Coverage Study Plan.

4. THREAT AND OPERATIONAL ENVIRONMENTS: Airland battle is predicted upon the integrated battlefield. The battlefield environment will consist of massed attacks at multiple points in every mission area, forward and rear, at every echelon of the battlefield to maximize the stress of the defenders, in an endeavor to capitalize upon their uncertainty and fatigue in order to break their will to resist at all echelons. Casualties in the first and second echelons will be inordinately high on a mass casualty level from the start of hostilities as compared to previous combat engagements. Tactical air, rocket, airborne, and airmobile attacks will disrupt traditional rear areas of safety while major ground thrusts will seek to break through, by-pass, and isolate the exhausted combat troops and spread havoc and panic among the vulnerable trains. Attention will have to be given to rear area defense (RAD). Electronic warfare will be used to maximize confusion and demoralization. As intensity escalates, persistent chemical agents will be used on selected critical facilities and re-supply routes in the rear and to suppress units which have been by-passed. Nonpersistent chemicals and nuclear strikes may be directed against suitable targets. Biological (infectious) agents and microwave weapons (beyond the conventional laser rangefinders) which produce mental disturbance may be expected as future weapons deployable on the modern battlefield. Sustained combat operations will affect personal performance at all echelons. All movement and communication non-essential to tactical mission support will be terminated. Chaplain movement will be at high risk, when authorized, and limited due to the threat configuration. Replacement material and personnel will be hampered by the rear area threat and high casualty rates at all echelons in the battlefield. Determination of defense situations and attack posture will be difficult due to electronic warfare impact on communications. Stress and fatigue induced by the shock of high casualties; unrelenting enemy assault by conventional and unconventional weaponry; and the absence of rest and recuperation sites/opportunities will necessitate a degradation of personnel effectiveness for combat and support activities. Military personnel will be strained beyond prior human experience. Ministry to casualties RTD, contaminated personnel, and lethally radiated personnel will be a new frontier for pastoral care. The medical support system will provide health care in an "austere, but adequate" environment. Chaplain support to these health care providers and commanders working within this medical support system who do survive the threat will require ministry to supplement their increasing spiritual and psychological needs as they are taxed beyond their normal endurance. The possibility of the

threat decimating the health care system and depriving the medical care providers of necessary materials, personnel, and logistics to care for casualties will drain the spiritual resources of the staff attempting to cope with the exegencies of the integrated battlefield. Chaplain support will be required to assist the medical care providers in conceptualizing their needs along religious lines. In general, the chaplain support to casualties and staff will be affected in the same degree as CSS, CS, and combat functions on the battlefield will be affected by weather, terrain, concealment, movement and the threat.

5. SUPPORT REQUIREMENTS: To be determined.

6. MILESTONE SCHEDULE:

a. 31 Jan 85 - Completion date for Literature Search.

b. 29 Mar 85 - Completion date for Data Collection (pending 7th Infantry Division testing).

c. 12 Apr 85 - SAG Halfway Meeting at 0800 at USACHCS.

d. 15 May 85 - Completion of first draft, staff to DACH.

e. 4 Jun 85 - Internal Process Review (IPR).

f. 3 Jul 85 - Complete analysis of study and staff with MACOM and DACH.

g. 6 Aug 85 - Return of coordinating draft.

h. 13 Aug 85 - Study ending SAG.

i. 18 Sep 85 - Completion date for study report to USACHS.

j. 27 Sep 85 - Completion date for study report to TRADOC.

7. STUDY ADVISORY GROUP:

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HSHA-CDS
SUBJECT: TRADOC Study Plan AR 5-5 "Chaplain Support to Casualties on the Airland Battlefield" ACN 064346

8. STUDY PROJECT OFFICER: USACHCS POC for this study is within the Academy of Health Sciences, US Army, Fort Sam Houston, Texas, Directorate of Combat Developments, Concepts Division, Special Studies Branch, Chaplain (LTC) David W. Williams, AUTOVON 471-3403/7751. TRADOC action control number is ACN 064346.

FOR THE COMMANDANT:

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as

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REFERENCES:

a. CSSMAA Lvl II "Personnel Service Support Report," July 1982, Chapter 6, Soldier Support Center. DD&CD, Ft Ben Harrison.

b. CSSMAA Lvl II "Battlefield Religious Coverage Plan," October 1981 USACHCS, Fort Monmouth, NJ

c. FM 16-5, Chapter 4, "Religious Support in Combat" (DRAFT)

d. Concepts Study - "Augmentation of OM Team" May 1984, AHS-DCD Fort Sam Houston, Texas

e. CSSMAA Lvl II "Medical Substudy", AHS-DCD, Fort Sam Houston, Texas

f. Concepts Study - "Interim Operational Concept Medical Support Light Infantry Division" AHS-DCD, Fort Sam Houston, Texas

g. Concepts Study - "Interim Operational Concept Medical Support Heavy-Light Infantry Division", AHS-DCD, Fort Sam Houston, Texas

h. MAA "Combat Psychiatry and Mental Health Services Report" December 1983, AHS-DCD, Fort Sam Houston, Texas

i. Military Review, June 1983, Vol. LXIII No 6 "Airland Battle Doctrine, Not Dogma"

j. HSCD Report #81-011 "Casualty Estimation Sub-study: DNBI Rates", August 1981, AHS-DCD, Fort Sam Houston, Texas

k. SPR Study, June 1984, "Augmentation Concept for Corps and COMMZ Management of Nuclear Weapons Casualties" AHS-SPR, Fort Sam Houston, Texas

l. USC&GS Study Study Paper, April 1983, "The Army Chaplain's Ministry as it Relates to the psychological Implications of an NBC Environment", USC&GS, Ft. Leavenworth, KS. Ch(MAJ) Joseph E. Miller

m. "The Modular Medical Support System": Division Level Medical Support in the 80's and Beyond. AHS-DCD, Ft Sam Houston, TX, Feb 84

ADMINISTRATIVE APPENDIX B

ESSENTIAL ELEMENTS OF ANALYSIS

1. What is the definition of casualty?

Finding: Casualties are any persons who are lost to their organization by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing in action, beleaguered, besieged, or detained.

2. What is the UMT function in support to casualties?

Finding: The UMT's function is to affirm the intrinsic worth of all soldiers, support their right to the free exercise of religion, and provide pastoral care and counseling, nurture, religious ministries and coverage grounded in religious faith, hope, and love, that promote readiness, healing, stabilization, stress reduction, morale, commitment, moral and spiritual fitness, ethical and spiritual values, spiritual growth, reconciliation with God and others, theological meanings,religious life, and total well-being.

3. What functions are considered essential chaplain support to casualties by religious groups?

Finding: Almost all religious groups consider religious ministry by chaplains representing God and religious communities of faith as essential, especially for casualties who are dying.

Eastern Orthodox and Roman Catholic churches have specific required rites for the dying. Jewish tradition views the deathbed confessional as important to the transition to the world to come. Many Protestant groups view baptism as essential.

Ministry facilitates peace with God and others, easing the transition. Many religious groups also consider prayers, anointing, laying on of hands, and sacraments as essential to rapid recovery from injuries and healing.

4. What is the soldier expectation of chaplain support to the casualty?

Finding: Soldiers expect chaplains to be there with them, as historically chaplains have always been there on the battlefield to provide the wounded and dying with help and consolation.

5. Where will chaplains be located organizationally in the medical support chain to provide pastoral care to casualties?

Finding: Unit Ministry Teams organic to maneuver units will be moving among soldiers offering encouragement immediately prior to the battle phase. They will not be prepositioned at battalion aid stations as previous doctrine suggests.

Brigade and division UMTs will provide coverage for brigade and division clearing stations. UMTs organic to medical units will provide religious support and coverage for casualties within corps level medical facilities.

6. What moral, ethical, and societal value factors contribute to an enhancement or a degradation of esprit in the care of casualties in their RTD?

Finding: Commitment is the greatest motivating value which enhances esprit in casualties returning to duty. Commitment may be to the organization (buddies), to personal success, and/or to moral purposes.

Responsive and responsible leadership, candor, shared experiences, interdependence, and trust are essential to building unit cohesion that sustains organizational commitment.

Personal integrity, courage, competence, and achievements, especially as leaders recognize and affirm them, are essential to sustaining commitment to self.

Shared moral codes, world views, belief systems, and cultural values help sustain commitment to moral purposes. The marks of commitment are loyalty, selfless service, and duty.

7. What pastoral care actions contribute to the rapid return to duty of casualties?

Finding: Assisting soldiers to retell their story until it is purged of its horror, to reframe, relabel, or contextualize their experiences theologically, and to integrate their experiences into frameworks of meaning that facilitate acceptance and coping emotionally contribute to casualties' rapidly returning to duty.

Supporting soldiers in their search for God and helping them to resolve crises of faith, grief, and guilt are also supportive. The response to EEA 12 lists other preventive tasks.

8. What are the expectations of commanders of the UMT in assisting in the care of casualties?

Finding: Commanders expect UMTs to be "with the troops," providing help and consolation for the wounded, helping to build and sustain faith, providing for human needs, caring for soldiers' welfare, and providing a moral framework for the military community. They expect chaplains to provide ministries of worship, sustaining, guiding, and caring for the dying. They expect chaplains to provide for the spiritual needs of soldiers.

Commanders think the UMT is best located either in the battalion aid station (43.78%) or where the fighting is the heaviest (28.99%).

9. What is the relationship between the ratio of battle stress to WIA casualties and the utilization of the chaplain in providing pastoral care in the medical model?

Finding: One out of every three casualties may be a battle fatigue casualty. Unit Ministry Teams organic to maneuver battalions will be the only available religious resource in Echelon I and a primary resource in Echelon II to care for these casualties.

Emerging medical doctrine projects assigning one chaplain to each combat stress control platoon, which is located in the division to provide care for stress casualties not hospitalized. Hospital UMTs provide crisis and stress ministry for stress casualties hospitalized in Echelon III.

UMTs provide support that is different from, yet complementary to that provided by medical treatment personnel, as ministry offers and elicits spiritual coping resources. UMTs assist casualties in their search for God and meaning. Their focus is spiritual. Their model for ministry is theological rather than medical and is related to spiritual conditions rather than medical conditions.

10. What chaplains should have training in psychology to provide pastoral care to BSI?

Finding: All chaplains who served hospitals in Vietnam responded that it would be definitely beneficial for chaplains to have psychological training. One chaplain replied, however, that one need not make him/her a psychologist.

11. What chaplains should have training in ATLS (advanced trauma life saving support) in order to provide support to casualties?

Finding: None, although all UMTs as soldiers should be highly trained and proficient in providing first aid.

12. What is the preventive role of chaplains in the management and treatment of stress casualties?

Finding: UMTs promote development and reinforcement of inner strengths, stability, resources, belief systems, world views, value systems, frameworks of meaning, and faith that will aid soldiers in coping with the chaos and horror of battle. They support good nutrition, adequate rest, physical fitness, and developing supportive interpersonal relationships.

UMTs offer opportunities for spiritual renewal, worship, study, and receiving sacraments. They teach stress reduction techniques, such as creative visualization, reframing, and prayer. They teach communication skills to strengthen interpersonal relationships, affirm moral behavior congruent with personal and social values to reduce the incidence of guilt, and teach religious perspectives toward death to aid soldiers to cope with the possibility of their own deaths.

UMTs pray with and for soldiers. They provide Scriptures, other religious literature, and religious symbols such as crosses and rosaries for soldiers to carry with them.

13. What is the role of laity in assisting the UMT in providing support to casualties?

Finding: Lay persons are an invaluable resource in providing religious support to casualties, particularly the ministry of sustaining or being with buddies who are suffering.

UMTs as a limited resource for widely dispersed units will not always be where casualties are. The laity provide ministry to buddies as they provide first aid or combat lifesaving to buddies. They can assure the wounded and dying of God's love, God's strengthening and comforting presence, and God's forgiveness.

14. What level of proficiency should the UMT have in first aid to provide effective support to casualties?

Finding: UMTs should have the highest level of proficiency that is possible, but should not be trained as combat lifesavers or to provide medical treatment beyond first aid. This would too seriously detract from their primary function of providing religious ministry to all soldiers on the battlefield. In emergency situations UMTs may choose to assist medical treatment personnel, such as: by carrying litters, holding pressure points, or going for help.

15. How does the deployment of medical units impact upon the chaplain's capacity to support casualty care?

Finding: Emerging health service support doctrine suggests that commanders may deploy medical units only partially at times or as modules. They may not include either one or both members of the Unit Ministry Team in these units.

Consequently, casualties may not receive religious support from UMTs organic to medical units, or until evacuated to a casualty collection location at which there is a UMT. Brigade, task force, division, and corps chaplains cannot assume that evacuated casualties will have received essential ministries. Augmenting UMTs may provide this support.

16. What are the capabilities of and requirements for chaplain support to casualties during the phases of battle on the integrated battlefield?

Finding: During the prebattle phase UMTs provide anxious soldiers with a ministry of presence, crisis and stress ministry, ministry of guiding, sacramental ministry and ministry of worship. They provide spiritual reassurance and encouragement.

During the battle phase they provide religious support to casualties for whom they provide ministry of dying, ministry of sustaining, and crisis and stress ministry.

During the post-battle phase, those suffering stress and trauma receive the ministry of dying, ministry of sustaining, crisis and stress ministry, ministry of worship, sacramental ministry, and ministry of celebration. During lulls UMTs offer small group counseling and services. During withdrawals, UMTs

minister to casualties who may be left behind, perhaps themselves risking capture or death.

During reconstitution, UMTs assist in rebuilding the emotional, psychological, and spiritual strength of the unit's surviving members and replacements. They conduct religious services which honor the dead and console the living. They offer intense individual and group pastoral counseling.

17. What are the constraints of the integrated battlefield/evironment upon the chaplain's capability to provide support to casualties?

Finding: Threat factors which will constrain the UMT as they provide ministry to casualties include: difficulty in locating casualties in widely dispersed units, dispersed holding areas for casualties awaiting evacuation, many deaths prior to evacuation, impaired communication to discern casualty locations, and high risk movements to casualty locations.

Others are: attacks, disruptions, and casualties in all echelons, possible attacks against casualty treatment locations, difficulties in ministering in MOPP, and high risk of UMTs becoming casualties as they minister to soldiers in forward areas.

18. What is the chaplain's capability to provide support to mass casualties?

Finding: The task force chaplain is responsible for analyzing mass casualty situations and coordinating religious coverage. Brigade and division chaplains monitor requirements for ministry.

By definition mass casualties exceed capabilities. Therefore in order to provide all the required and essential religious coverage and ministry, other UMTs must augment primary UMTs.

When UMTs do not have coordinated mass casualty plans for religious coverage for mass casualties in their units, they provide only a reactive ministry.

19. How does the categories of battlefield casualties impact on the ministry requirements to those same casualties?

Finding: Requirements for religious support are in direct proportion to the number of casualties who are categorized as dying, triaged as expectant, diagnosed as having life-threatening conditions, suffering high levels of pain, suffering significant losses, and/or suffering from combat stress or battle fatigue.

For an example, religious support requirements are greater for amputees than for those with minor flesh wounds. Or multiple fragment wound category casualties require more religious support than do those with fractures. Ministry to the dying usually requires more time than crisis and stress ministry.

Since mid-high intensity conflicts and more lethal battlefields generate a greater number of seriously wounded or dying category casualties, requirements for religious support are greater in these combat environments.

20. What is the scope of chaplain support requirements for the RTD, minimal care facilities, NBC casualties, and casualty evacuation?

Finding: Since one out of three casualties may be a combat stress reaction casualty, and being wounded or injured increases stress, as many as one third of all casualties returning to duty may require some level of crisis and stress ministry.

Commanders may retain many of these casualties in holding areas or minimal care facilities for 1 - 30 days prior to their return to duty. When these areas are collocated with hospitals, requirements for religious coverage may exceed hospital UMT capabilities. Then augmenting UMTs must provide coverage.

NBC casualties will primarily require ministry to the dying, ministry of sustaining, and crisis and stress ministry. UMTs organic to affected units will provide this ministry. Augmenting UMTs at decontamination points or at medical treatment locations may provide other ministries.

Casualties awaiting evacuation in holding areas also require coverage. UMTs organic to maneuver units best provide Echelon I and II ministry. Corps or hospital UMTs best provide Echelon III and IV ministry.

21. What is the chaplain's function in providing support to minimal care battalions for patients triaged as expectant?

Finding: UMTs provide ministry to the dying for all patients triaged as expectant. They provide this ministry daily. Distinctive faith group and denominational representatives provide essential rites for the dying. The senior chaplain in the area coordinates coverage.

22. What resources does the concept of "volunteerism" offer in the context of augmenting chaplain support to casualties asa practical application of lay participation?

Finding: See answer to EEA 13.

23. How can the chaplain provide support to both individual and unit target groups in the provision of casualty care?

Finding: Whereas much religious support is individualized, UMTs provide opportunities for group worship, study, support, counseling, and fellowship. UMTs also provide opportunities for small group worship and discussion in wards, holding areas, and medical treatment locations for non-ambulatory patients.

24. What is the ability of the chaplain UMT to transcend the personal fear of survival and sustain support of casualties?

Finding: Spiritually, ethically, and psychologically prepared UMTs do have the ability to transcend personal fears of survival. They need theological world-views, spiritual rationales, ethical perspectives, and psychological stability which support selfless service and personal sacrifice.

UMTs who are able to maintain wholeness, hope, meaningfulness in ministry, trust, fervency, and assurance of God's unconditional grace in the face of trauma are those who have a theological world-view which affords meaning to human suffering, inhumaneness, and irrationality.

UMTs must embrace as an ethical imperative their being wherever there are suffering people in need, regardless of whether or not the war seems ethical to them, and regardless of the cost to personal well-being. Chaplains trained to be relatively sophisticated in theological concepts and faith perspectives are most likely to possess this ability.

25. What is the ministry to the health care providers under the battlefield scenario?

Finding: Medical treatment personnel experience crises of faith, fear, grief, guilt, and despair in varying degrees as they provide medical care for casualties.

UMTs provide ministries which help those who are experiencing crisis and stress to cope with the horrors of the battlefield, those who are fearful to find the courage to do their job, those who are grieving to resolve their grief, those who feel guilty to forgive themselves as well as to receive forgiveness from God and others, and those who are in despair to discover hope beyond the immediate.

UMTs provide a ministry of guiding to those in ethical dilemmas. They offer services of worship, times for reflection and study of sacred writings, and opportunities for supportive fellowship. UMTs celebrate with staff their successes, victories, and joys.

26. What yardstick is indicated for manpower requirements in providing chaplains to casualties?

Finding: Manpower requirements can be established through analyzing what ministries distinguishable categories of casualties most require.

The categories include: those triaged as expectant, those with life-threatening conditions, those with irreversible conditions and permanent disabilities, those facing long term hospitalization and treatment, and those who are neuropsychiatric, combat stress, and battle fatigue casualties.

Other categories who benefit from ministry are pre-surgery patients and those experiencing dilemmas. A certain percentage of casualties also request sacramental ministry and participate in the ministry of worship. Some casualties even celebrate and benefit from a ministry of celebration.

ADMINISTRATIVE APPENDIX C

FOLLOW-ON ACTION

1. Expansion of discussion of Unit Ministry Team (UMT) religious support to casualties in Unit Ministry Team doctrine to reflect this religious support's proportionate importance. Action agency: U. S. Army Chaplain Center and School.

2. Discussions with Army Medical Department as to how religious support can be more clearly referenced and included in future health service support doctrinal writings. Action agency: U. S. Army Chaplain Center and School; Concepts Division, Directorate of Combat Development, Academy of Health Sciences; Directorate of Training and Doctrine, Academy of Health Sciences.

3. Coordinated mass casualty plans for each division and unit. Action agency: Office of the Chief of Chaplains for policy statement; U. S. Army Chaplain Center and School for additions to doctrine; each division and unit for implementation.

4. Separate study of religious support to casualties within an NBC environment as part of the NBC environment study. Action agency: Soldier Support Center; Concepts Division, Directorate of Combat Developments, Academy of Health Sciences; U. S. Army Chaplain Center and School

5. Manpower Authorization Requirement Criteria Study relating hospital religious support to patient classifications. Action agency: U. S. Army Chaplain Center and School.

6. Expansion of UMT training in religious support to casualties. U. S. Army Chaplain Center and School.

7. Expanded training for UMTs in providing religious support to members of religious groups other than their own. Action agency: U. S. Army Chaplain Center and School.

ADMINISTRATIVE APPENDIX D

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CHAPTER III

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[2]Ibid., p. 20.

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ADMINISTRATIVE APPENDIX E

GLOSSARY

AMEDD - Army Medical Department

AO - Area of Operations

ATLS - Advanced Trauma Life Support

BAS - Battalion Aid Station

BSA - Brigade Support Area

BSI - Battle Stress Individual

CAA - Concepts Analysis Agency

COMMZ - Communications Zone

CONUS - Continental United States

CPE - Clinical Pastoral Education

CSC - Combat Stress Control

CSH - Combat Support Hospital

CZ - Combat Zone

DEPMEDS - Deployable Medical System

DIH - Died in Hospital

DNBI - Disease Non Battle Injury

DSA - Division Support Area

EAC - Echelon Above Corps

EEA - Essential Element of Analysis

Echelon - Level of Combat or Casualty Care

EVAC - Evacuation Hospital

FASTALS - Force Analysis Simulation and Theater Administrative and Logistics Support

FORCEM - Forces Combat Evaluation Model

FLOT - Forward Line of Own Troops

GH - General Hospital

HSSALB - Health Service Support AirLand Battle

IMA - Individual Mobilization Augmentee

IOC - Interim Operational Concept

KCM - Killed, Captured, or Missing

KIA - Killed in Action

Echelon/Level I - Care/treatment provided by designated individual and elements organic to combat, combat support,an units of the area support battalion.

Echelon/Level II - Care/treatment rendered at the clearing station in division and corps

Echelon/Level III - Care/treatment provided in a medical facility staffed and equiped to provide resuscitation, initial wound surgery, and postoperative treatment.

Echelon/Level IV - Care/treatment provided in a General Hospital staffed and equiped for general and specialized medical and surgical care

Echelon/Level V - CONUS based medical care

MAA - Mission Area Analysis

MARC - Manpower Authorization Requirement Criteria

MASF - Mobile Air Staging Facility

MASH - Mobile Army Surgical Hospital

METT-T - Mission, Enenmy, Terrain, Troops, Time Available

MOPP - Military Operational Protective Posture

MOPP IV - Full MOPP Protective Posture

MSPR - Medical Systems Program Review

MUST - Medical Unit, Self-contained, Transportable

NATO - North Atlantic Treaty Association

NBC - Nuclear, Biological, Chemical

NRTD or NON RTD - Non Return to Duty

NTC - National Training Center, Fort Irwin, CA

O & O - Operations and Organization

OPFOR - Opposition Forces

PATGEN - Academy of Health Sciences Patient Flow Model

R & R - Rest and Recuperation

RTD - Return to Duty

SME - Subject Matter Expert

SOP - Standard Operating Procedure

STAY - Length of Stay in Hospital

SUR - Surgical Patient

SRC - Standard Requirement Code

TAA - Total Army Analysis

TRIAGE - Sorting of Casualties to Prioritize Requirements for Treatment

UMT - Unit Ministry Team

USACHCS - United States Army Chaplain Center and School

USSR - Union of Soviet Socialist Republics

WIA - Wounded in Action

SUBSTANTIVE APPENDIX A

THREAT

1-1. Threat Overview

The AirLand battlefield is characterized by:

- Highly lethal weapon systems
- Intense around the clock combat lasting several days
- Broad, ill-defined fronts
- Massive concentration of forces and fires
- Attacks upon every echelon simultaneously
- Formidable enemy air power
- High risk movements at every level
- High probability of NBC early in the battle
- Electronic warfare
- Directed energy warfare
- Unconventional warfare
- Lack of secure areas for rest and recuperation (R & R)

The threat will vary according to the intensity and location of the conflict. A European, and possibly a Southwest Asian, scenario would most likely be a high intensity environment characterized by broad frontages, deep targets, and enemy penetrations of varying depths.

Other middle to low intensity environments, usually associated with Third World conflicts, would be most likely characterized by poorly defined fronts, semiautonomous dismounted operations conducted at varying depths, and rear area security problems.

The spectrum of conflict may vary from low risk and high probability of terrorism to the high risk and low probability of strategic nuclear warfare as depicted in Figure 1-1. This figure does not reference the possibility of NBC weapons being used in low intensity conflicts.

1-2. Medical Threat

Any event that can reduce the combat, combat support, or combat service support effectiveness by producing medical casualties is a medical threat.

Casualties are any persons who are lost to their organization by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing in action, beleaguered, besieged, or detained. (NATO definition)

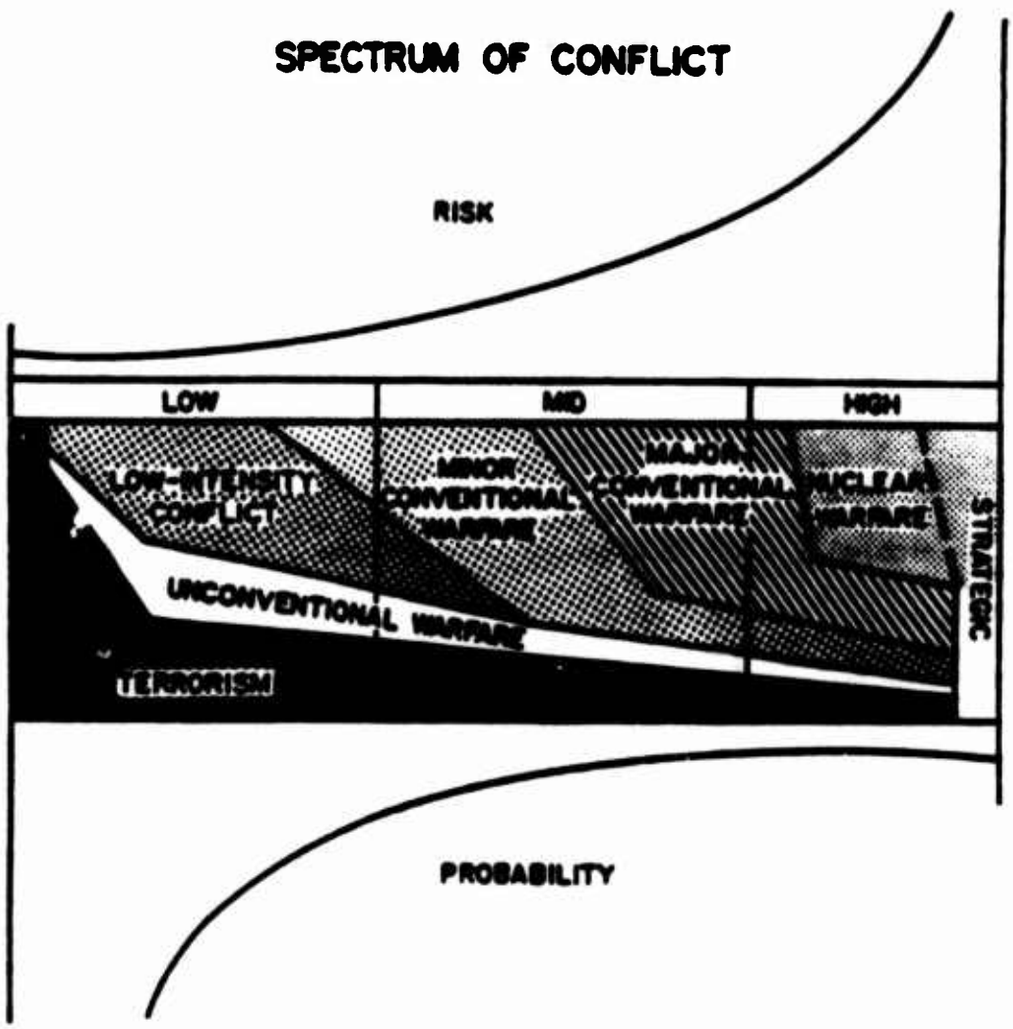

Figure 1-1. Spectrum of conflict.

Depending upon the scenario, the number and mix of medical casualties will vary. Light to middle intensity conflicts produce fewer casualties of a different mix than do high intensity conflicts. Individual wounds, injuries, and diseases, however, may be just as severe.

Casualty projections also vary depending upon which computer simulation model is used to project the numbers and mix of casualties.

Total Army Analysis 93 (TAA 93), derived from the Force Analysis Simulation and Theater Administrative and Logistics Support (FASTALS) model and the Forces Combat Evaluation (FORCEM) model by the Concepts Analysis Agency (CAA), is the model being used in this study.

Other past played models have projected considerably higher casualty rates. The Corps and Division Evaluation (CORDIVEM) model projected casualties which far exceeded medical capabilities in a high intensity conflict.

According to the AirLand Battle Phase III study, a corps' medical requirements exceed capabilities in beds required, surgical capabilities, and evacuation requirements. Corps medical evacuation assets were not sufficient to evacuate the wounded from the point of wounding to the level of required medical treatment, nor were United States Air Force assets sufficient to evacuate to CONUS those casualties requiring long-term medical treatment.

According to most computer simulation models and based upon past experience, the killed in action to wounded in action ratio will be approximately one to five. Most wounds will involve hemorrhages. Approximately one in four wounds will be multiple fragment wounds.

Other medical threat factors on the integrated battlefield include:

- Mission performance degradation due to protective postures
- Mass casualties
- Difficult triage choices
- Difficulties of moving treatment facilities
- Supply and resupply disruption
- Inadequate blood supplies
- Contamination of unit equipment, supplies, and personnel
- Disruption of communication lines
- Equipment damage (high altitude electromagnetic pulse)
- Combat stress
- Difficulties in maintaining command and control

Medical treatment resources will also be vulnerable to enemy penetrations into rear areas, where most treatment resources are located.

Unconventional warfare, terrorism, long range artillery and air attacks will affect not only medical treatment, but also resupply of medical materiel and supplies. Prepared air fields required for evacuation, fixed support facilities, including hospitals, and other permanent facilities may be primary targets.

Ambulance squads and forward deployed medical treatment teams will be vulnerable to enemy armored combat vehicles, particularly during movements and evacuations, in addition to other combat hazards.

In the vicinity of the FLOT, medical personnel, mobile treatment teams, and evacuation vehicles in a high intensity conflict can expect massive artillery fires, enemy breakthroughs, and isolation. Air ambulances will be vulnerable to antiaircraft artillery and surface to air missiles.

TAA 93 does not project casualties within an NBC scenario. Nuclear warfare will in all probability produce a far greater incidence of burn casualties, eye injuries, hearing loss, and battle fatigue.

Just the uncertainty of exposure and/or the unknown amount of exposure to radiation will exacerbate the stress. Mortally radiated soldiers with no other serious wounds, because of radiation's delayed effects, could be used in combat roles until they are no longer functional.

Chemical warfare will produce similar stresses. Uncertainty of the type and/or amount of exposure, delayed effects, and uncertainty concerning the completeness of decontamination will increase stress.

Treatment procedures may be prolonged due to decontamination. Chemical contamination will also have a cumulative effect upon the treatment of other wounds. Exposure to mind altering chemicals will affect how soldiers are used in combat roles.

Soldiers who are not direct chemical casualties will have the pharmacological effects of low dose, cumulative exposure to chemical warfare agents. These mostly psychological, neurological, or nonspecific symptoms may impair morale.

Soldiers may will have the psychophysiological symptoms of heat stress, fatigue, and antidote reactions due to excessive use of atrophine in relation to exposure. Maintaining personal hygiene may be difficult.

Biological warfare will add to those stresses cited above the stress of exposed soldiers being infectious to others.

NBC warfare would probably produce medical requirements which far exceed medical capabilities in terms of medical personnel, medicines and antidotes, and other treatment resources. The number of beds and evacuation resources will most likely be inadequate.

Medical treatment in a contaminated environment within MOPP IV will be extremely difficult, if not impossible. Decontamination may not always be complete. Maintaining clean environments will be difficult. Evacuating soldiers from contaminated areas will be difficult without sending ambulance squads into contaminated areas, greatly increasing their risk of contamination.

1-3. Combat Stress Threat

Battle fatigue will be the greatest in high intensity conflicts. The current doctrine of the Union of Soviet Socialist Republics (USSR), considered to be the principal adversary in any such conflict, emphasizes producing "battle paralysis" using combined arms.

Other combat stress factors are:

- Highly intense, mass casualty battles
- Uncertainty of NBC and global war
- Continuous operations, sleep loss
- High risk of wounding by "friendly fire"
- High lethality
- First combat for most junior soldiers
- Unconventional warfare and terrorism
- Exhaustion
- Unit attrition
- Degraded communications
- Isolation
- Reduced resources for rest and recuperation
- Unit leadership

Projections are that as many as one out of three or four casualties will be a battle fatigue casualty requiring some form of medical or other treatment. The incidence of battle fatigue is in direct proportion to the conflict's intensity.

1-4. Threat Implications for Religious Support to Casualties

a. Mid-High intensity conflict

- Difficulty in locating widely dispersed units
- High casualty rates in all echelons
- Dispersed holding areas for casualties awaiting evacuation requiring religious coverage
- Many deaths prior to evacuation to treatment locations
- Impaired communications to discern casualty locations
- Highrisk movements to casualty locations, particularly lateral movements
- Mass casualty ministry requirements
- Not enough medical treatment personnel, resulting in wide use of combat lifesavers and other nonmedical personnel to provide treatment
- Attacks and disruptions in rear areas
- Possible attacks against casualty treatment facilities
- Holding areas for casualties awaiting surgery
- Holding areas for casualties awaiting beds
- Probably a 30 day theater evacuation policy
- Many unconscious and disoriented casualties
- Competing priorities for ministry

- Difficulties of ministering in various MOPP levels
- Combat stress
- Austere support
- High risk of Unit Ministry Teams becoming casualties
- Lack of secure areas for group religious ministries

b. Low intensity conflict

- Difficulty in locating widely dispersed units
- Small deployed units without organic chaplains receiving the greatest number of casualties
- Air evacuation to maximum extent possible and as far forward as possible, decreasing likelihood of ministry prior to evacuation
- Fewer casualty collection points and holding areas requiring religious coverage
- Short theater evacuation policy
- More frequent evacuation off shore or out of AO
- Hospitals with organic chaplains only partially and austerely deployed, frequently without organic chaplain
- Long lines of communication increasing difficulty of locating casualties in evacuation stream
- Austere transportation resources affecting movements to casualty locations and both members of the Unit Ministry Team traveling together
- Combat stress related to the possibility of terrorism, unconventional warfare, and sabotage
- Austere deployment of combat stress control units
- Aeromedical evacuation support to indigenous and allied forces, requiring knowledge of various indigenous and allied religious beliefs and practices

SUBSTANTIVE APPENDIX B

METHODOLOGY

The methodology used in conducting this study included: literature search, data collection, subject matter expert panel input, observation, and analytical interpretation.

Military doctrine, both Chaplain Branch and Army Medical Department, were searched for references to Unit Ministry Team religious support to casualties.

Although during the battle phase, doctrine states that the Unit Ministry Team's highest priority is to care for casualties (FM 16-5), chaplain branch doctrine says nothing about what constitutes this religious support and little about the religious coverage of casualties (FM 16-5, pages 54, 55). Most references are to organization for combat and the responsibilities of Unit Ministry Teams in each echelon.

During the post battle phase, doctrine states that stress and trauma casualties receive religious support priority. It only mentions sacramental ministry and memorial services as ministries provided.

"Rebuilding the emotional, psychological, and spiritual strength of the unit's surviving members and replacements" is the only specific statement of function (FM 16-5, p. 58). Other references are to providing pastoral care, consoling the living, honoring the dead, and individual and small group counseling and services (FM 16-5, p. 57f).

Field Circular 16-51, September, 1986, does address how UMTs provide battle fatigue ministry. It includes history, definitions, causes, types of battle fatigue, responses, responsibilities, a UMT operating concept, additional religious support considerations, and task lists. Historical sections yielded many insights into battlefield trauma, requirements for ministry, and possible Unit Ministry Team responses.

Army Medical Department doctrine contains no references to what Unit Ministry Teams do to provide religious support to medical casualties. Tables of Organization and Equipment do have brief descriptions of the duties of chaplains and chaplain assistants.

The emerging AMEDD combat stress interim operational concept does have brief descriptions of the duties of the chaplain and the chaplain assistant.

Military history, in particular the history of the chaplaincy, as it was reviewed, yielded many insights as to religious support provided to casualties in past conflicts.

Military history was researched for commanders' and other soldiers' expectations for religious support. Commanders' statements concerning the

importance of spiritual morale, the spirit, and spiritual health provided valuable insights into religious requirements on the battlefield.

Senior commanders' statements on the value of religious support provided by chaplains in previous wars provided verification that religious support is essential.

Articles written by veterans were surveyed for insights into battlefield needs for ministry to casualties. Articles written by nurses who served in Vietnam were of particular interest and provided many of the insights concerning requirements that medical treatment personnel have for religious support. Conclusions concerning religious support to medical treatment personnel are based primarily upon this research.

Particularly helpful was related research being done on post traumatic stress disorders among Vietnam veterans. This research provided not only data as to what soldiers in Vietnam experienced while there, but also insights into requirements for preventive religious support and other pastoral interventions on the battlefield.

Theological and pastoral care literature was surveyed for for concepts of pastoral care ministry to the dying, the injured, and the diseased. This literature yielded many insights and provided the basis for conceptualizing the identified spiritual conditions and ministries.

Insights contained in papers written by chaplains who served in Vietnam were used extensively to identify religious requirements, training needs, and requirements that UMTs have supporting theological world views and rationales.

Related psychological and sociological literature was surveyed for related concepts, yielding some parallels. Books and articles written and/or edited by psychiatrists, psychologists, and sociologists were helpful in conceptualizing spiritual conditions and identifying therapeutic needs and possible responses, particularly in caring for the dying.

Army Medical Department current and emerging doctrine was surveyed for operational concepts and descriptions of organization.

As health service support organization is in the process of changing, interface with chaplain organization is inconclusive. Needs, however, have not changed. The Combat Stress Control Interim Operational Concept helped identify combat stress reaction casualties' emotional needs and possible therapeutic responses.

Responses to two separate questionaires provided some basic data, reference requirements for religious support to casualties. One was sent to chaplains who served Mobile Army Surgical Hospitals (MASH-type), evacuation hospitals, and field hospitals hospitals in Vietnam. Another was sent to division chaplains.

Each questionaire yielded data useful in developing basic concepts and supporting requirements for religious support to casualties. These questionaires and applicable responses are included in Substantive Appendix D.

Some data was extrapolated from previous Manpower Requirement Authorization Criteria (MARC) studies and other conceptual papers and studies done by students and staff of the United States Army Chaplain Center and School. Also used were papers written at the Naval Chaplains' School.

Field training exercise after action reports which detailed religious support provided to casualties were reviewed for supporting data, requirements for religious support, and training observations and requirements. Of particular interest were after action reports of Unit Ministry Teams who trained at the National Training Center, Fort Irwin, CA.

The data base used in establishing religious support and manpower requirements was Total Army Analysis 93, as it applies to a 20 division NATO force in a European theater during the first 30 days of a high intensity conflict. Combined with the Academy of Health Sciences patient flow model (PATGEN), Echelon III and IV requirements for religious support were established. Although this is not basic data, it is included in Substantive Appendix D.

Other data was collected from Army Medical Department exercises, after action reports, concept statements, and studies. Medical treatment and chaplain personnel who were present during these exercises assisted by sharing observations and interpretations of training conducted.

Some basic, although subjective, data was collected in interviews of chaplains, medical personnel, and soldiers who served in Vietnam. These helped validate requirements and provided insights into the importance of supporting world views and theological conceptualizations.

A Subject Matter Expert panel was used to establish requirements for religious support and to validate conclusions. Initial outlines were presented for review and suggestions, as was the final product. Revisions were then made.

All materials were submitted for review by the Study Advisory Group, which met several times during the course of the study. The SAG rejected initial drafts. They approved subsequent drafts, as they were completely rewritten by another author using a different conceptual base.

Lastly, all materials were analyzed, interpreted, and then integated into conceptualizations of spiritual conditions, religious support requirements, training and manpower requirements, and religious support provided.

SUBSTANTIVE APPENDIX C

MODEL

No model was developed in the course of this study.

Total Army Analysis 93 and the Academy of Health Sciences patient flow (PATGEN) models were used to project the number and mix of casualties in Echelons III and IV.

The Combat Zone Assessment model (CZAR) was used to project the percentage of deaths by patient classification in Echelon II.

SUBSTANTIVE APPENDIX D

PATIENT DESCRIPTION AND TREATMENT DATA

The information in this listing is based upon the quadservice deployable medical systems (DEPMEDS) clinical data base created in December 1985 using 192 admissions per division slice per day based upon the 30 day peak average from Total Army Analysis 93 (TAA 93). The patient stream is derived from the Academy of Health Sciences PATGEN model.

Echelon/Level III Hospitals: Mobile Army Surgical Hospital (MASH)
Combat Support Hospital (CSH)
Evacuation Hospital (EVAC)

Echelon/Level IV Hospitals: General Hospital (GH)
Field Hospital (FH)

Echelon/Level V Hospitals: CONUS

Died in Hospital - DIH

Surgical Patient - SUR

Return to Duty from Echelons III or IV - RTD

Length of Stay in Days in Echelon V - STAY

Admissions listed as Echelon IV are direct admissions. Echelon IV admissions will also include casualties evacuated from Echelon III. Numbers represent the number in each classification admitted.

PATIENT CLASS DESCRIPTION	III	DIH-3	IV	DIH-4	SUR	RTD	STAY
1 Cerebral Concussion	175		9		N	Y	
2 Cerebral Concussion	417		23		N	Y	
3 Cerebral Contusion	130	9	11		YGH	N	127
4 Cerebral Contusion	537		42		N	Y	
5 Cerebral Contusion	51	6	3		Y	N	127
6 Cerebral Contus/Uncon	234		11		Y	N	150
7 Cerebral Contusion	55	3	3		Y	N	150
8 Cerebral Contusion	234		11		Y	N	41
9 Cerebral Contusion	110	6	4		Y	N	150
10 Cerebral Contusion	112		5		Y	N	39
11 Intracranial Hemorrhage	116	34	6	1	Y	N	127
12 Intracranial Hemorrhage	174		8		N	N	63
13 Scalp Wound	68		4		Y	Y	

14	Scalp Wound							
15	Face Fracture	61		5		Y	N	59
16	Face Fracture	84		7		Y	Y	
17	Face Wound	1660	33	75	1	Y	N	172
18	Face Wound	1680		75		Y	N	110
19	Face Wound	153		13		Y	N	113
20	Face and Neck Wound	358		32		Y	Y	
21	Eye Wound	1168		78		Y	N	67
22	Eye Wound	467		31		Y	Y	
23	Ear Wound	51		2		N	N	85
24	Ear Wound	39		1		N	Y	
25	Spine Fracture	69		5		YGH	N	88
26	Spine Fracture	162		10		N	N	54
27	Spine Frac/Quadriplegic	56		3		Y	N	497
28	Spine Frac/Paraplegic	97		6		Y	N	97
29	Spine Frac/cord damage	62	2	4		Y	N	496
30	Spine Frac/cord damage	155		8		Y	N	496
31	Intervertebral Disc Dis	58		3		YGH	N	47
32	Intervertebral Disc Dis	233		13		N	N	41
33	Sacroiliac Strain/Sprain	29		2		N	Y	
34	Sacroiliac Strain/Sprain							
35	Burn, Severe, Head/Neck							
36	Burn, Mod, Head/Neck							
37	Burn, Severe, Head/Neck	97		9		N	Y	
38	Burn, Mod, Head/Neck	107		16		N	Y	
39	Burn, Severe, Head/Neck	161		9		Y	N	90
40	Burn, Mod, Head/Neck	481		27		YGH	N	59
41	Clavicle Fracture	70		5		N	N	42
42	Shoulder Wound, Severe	2264		101		Y	N	61
43	Shoulder Wound, Mod	566		25		Y	N	54
44	Humerous Fracture	166		11		N	N	54
45	Upper Arm Wound, Severe	19		4		Y	Y	
46	Upper Arm Wound, Mod	178		25		Y	Y	
47	Upper Arm, Not Salvage	658		29		Y	N	67
48	Upper Arm Wound/Frac	3723		164		Y	N	66
49	Radius/Ulna Fracture	140		14		Y	N	49
50	Radius/Ulna Fracture	59		6		N	Y	
51	Forearm Wound, Severe	58		9		Y	N	60
52	Forearm Wound, Mod	212		23		Y	N	
53	Forearm Wound/Not Salvag	38		2		Y	N	66
54	Forearm Wound, Mod	217		15		Y	N	86
55	Hand Fracture, Severe	188		21		YGH	N	40
56	Hand Fracture, Mod	47		5		N	N	40
57	Hand Wound, Severe	136		18		Y	N	206
58	Hand Wound, Mod	317		42		Y	Y	
59	Hand Wound, Crushed	694		32		Y	N	57
60	Hand Wound, Mod	416		20		Y	N	86
61	Upper Extremity Crushed	9		2		Y	N	61
62	Upper Extremity Crushed	14		2		YGH	Y	
63	Shoulder Dislocation	6		2		N	Y	
64	Shoulder Dislocation	7		2		N	Y	
65	Elbow Fracture, Severe	26		2		Y	N	83

66	Elbow Fracture, Mod	4		2		N	N	39
67	Wrist/Hand Dislocation	15		3		Y	N	38
68	Wrist/Hand Dislocation							
69	Hand Amputation	346		16		Y	N	68
70	Forearm Amputation	34		2		Y	N	66
71	Full Arm Amputation	45		3		Y	N	72
72	Wrist Sprain							
73	Fingers Spain, Severe							
74	Fingers Sprain, Mod							
75	Upper Extr Burn 10%+							
76	Upper Extr Burn 10%-							
77	Upper Extr Burn 10%+	345		30		N	Y	
78	Upper Extr Burn 10%-	100		9		N	Y	
79	Upper Extr Burn 10%+	693		41		Y	N	77
80	Upper Extr Burn 10%-	298		17		Y	N	60
81	Rib Fracture, Severe	53		4		N	Y	
82	Rib Fracture, Mod	16		3		N	Y	
83	Lung Injury, Severe	4		2		Y	N	80
84	Lung Injury, Mod	16		2		N	Y	
85	Thorax Wound, Severe	75		5		Y	Y	
86	Thorax Wound, Mod	91		7		Y	Y	
87	Thorax Wound, Severe	1483	44	65	1	Y	N	100
88	Thorax Wound, Mod	1505		66		Y	N	38
89	Open Heart Wound, Severe							
90	Trunk Burn, Severe 20%+							
91	Trunk Burn, Mod 20%-							
92	Trunk Burn, Severe 20%+	72	2	7		N	N	33
93	Trunk Burn, Mod 20%-	61		5		N	Y	
94	Trunk Burn, Severe 20%+	396		22		Y	N	175
95	Trunk Burn, Mod 20%-	269		16		Y	N	147
96	Abdom Wound, Severe	331		18		Y	Y	
97	Abdom Wound, Mod	399		21		N	Y	
98	Liver Wound, Severe	15	1	2		Y	N	100
99	Liver Wound, Mod	62		5		Y	N	42
100	Spleen Wound, Severe	117	1	10		Y	N	39
101	Abdom Wound, Severe	485	4	22		Y	N	56
102	Abdom Wound, Mod	174	10	8		Y	N	41
103	Abdom/Liver Wound, Sev	83	4	4		Y	N	100
104	Abdom Wound, Mod	86	10	4		Y	N	41
105	Abdom/Spleen Wound, Sev	122		7		Y	N	38
106	Abdom/Kidney Wound, Sev	14		2		Y	N	40
107	Abdom/Kidney Wound, Mod	28		2		Y	N	40
108	Abdom/Bladder Wound, Sev	15		2		Y	N	120
109	Abdom/Bladder Wound, Mod	57		3		Y	N	37
110	Buttocks Wound, Severe	416		19		Y	N	62
111	Buttocks Wound, Mod	969		45		Y	Y	
112	Pelvis Fracture, Severe	15		2		YGH	N	69
113	Pelvis Fracture, Mod	23		2		N	N	39
114	Pelvis Wound, Severe	3		2		YGH	N	61
115	Pelvic Wound, Mod	2		1		YGH	N	58
116	Genitalia Wound, Severe	250		12		Y	N	85
117	Male Genitalia Wound	115		5		Y	Y	

118	Female Genitalia Wound	33		2		Y	N	85
119	Female Genitalia Crush							
120	Femur Fracture, Severe	233	4	27		Y	N	148
121	Thigh Wound, Severe	82		9		Y	N	60
122	Thigh Wound, Mod	264		34		Y	Y	
123	Thigh, Limb Not Salvage	1066		47		Y	N	28
124	Thigh Wound, Mod	4309		192		Y	N	64
125	Knee Shattered, Severe	902		42		Y	N	65
126	Knee Wound, Mod	180		9		Y	N	58
127	Tibia/Fibula Fracture	279		15		Y	N	115
128	Lower Leg Wound, Severe	149		14		Y	N	59
129	Lower Leg Wound, Mod	523		50		Y	Y	
130	Lower Leg, Not Salvage	1452		65		Y	N	61
131	Lower Leg Wound, Mod	5801		247		Y	N	145
132	Ankle/Foot Frac, Severe	547		75		Y	N	46
133	Ankle/Foot Fract, Mod	96		13		N	Y	
134	Ankle/Foot Wound, Severe	107		14		Y	N	58
135	Ankle/Foot Wound, Mod	365		47		Y	Y	
136	Ankle/Foot, Not Salvage	662		35		Y	N	61
137	Ankle/Foot Wound, Mod	2644		136		Y	N	116
138	Lower Extr Crush, Severe	98		6		Y	N	61
139	Lower Extr Crush, Mod	98		6		Y	N	57
140	Hip Dislocation, Severe	13		2		Y	N	40
141	Knee Ligament Tear, Sev	41		7		N	N	59
142	Knee Ligament Tear, Mod	188		29		Y	Y	
143	Toes, Dislocation, Mod	13		3		N	Y	
144	Foot Amputation	238		15		Y	N	61
145	Lower Leg Amputation	352		17		Y	N	67
146	Above Knee Amputation	14		2		Y	N	61
147	Above Knee Amputation	130	2	6		Y	N	61
148	Ankle Sprain, Severe	263		27		Y	Y	
149	Ankle Sprain, Mod	905		109		N	Y	
150	Lower Extr Burn, Severe							
151	Lower Extr Burn, Mod							
152	Lower Extr Burn, 30%+	80		7		N	N	55
153	Lower Extr Burn, 30%-	121		11		Y	N	240
154	Lower Extr Burn, 30%+	495		29		Y	N	145
155	Lower Extr Burn, 30%-	496		29		Y	N	60
156	Hand/Foot Blisters, Mod							
157	Bites and Stings, Severe	6		1		N	Y	
158	Bites and Stings, Mod							
159	MFW, Brain/Chest	1158		52		Y	N	277
160	MFW, Brain/Abdom	970	87	42	3	Y	N	277
161	MFW, Brain/Abdom/Kidney	498		22		Y	N	280
162	MFW, Brain/Abdom/Bladder	493		23		Y	N	77
163	MFW, Brain/Abdom/Spleen	467		20		Y	N	171
164	MFW, Brain/Abdom/Liver	490		22		Y	N	293
165	MFW, Brain/Low Limbs Am	2549		113		Y	N	290
166	MFW, Chest/Abdom/Colon	447		19		Y	N	56
167	MFW, Chest/Abdom/Kidney	215		10		Y	N	62
168	MFW, Chest/Abdom/Bladder	224		10		Y	N	62
169	MFW, Chest/Abdom/Spleem	216		10		Y	N	40

170	MFW, Chest/Abdom/Liver	215	6	9		Y	N	57
171	MFW, Chest/Limbs/Vascul	4424	44	189	1	Y	N	77
172	MFW, Abdom/Colon/Blad	127		5		Y	N	82
173	MFW, Abdom/Colon/Spleen	59		3		Y	N	56
174	MFW, Abdom/Colon/Liver	60	1	3		Y	N	82
175	MFW, Abdom/Colon/Limbs	2382	23	101	1	Y	N	173
176	MFW, Abdom/Pelv/Kid/Liv	61	1	3		Y	N	80
177	MFW, Abdom/Pelv/Spl/Blad	65		2		Y	N	48
178	MFW, Abd/Pelv/Kid/Limbs	1203	12	50		Y	N	172
179	MFW, Abd/Pelv/Blad/Limb	1259		55		Y	N	42
180	MFW, Abdom/Spleen/Limbs	1201	132	50	5	Y	N	174
181	MFW, Abdom/Liver/Limbs	1240	37	52	1	Y	N	56
182	MFW, Brain/Chest/Limbs	3325	66	144	2	Y	N	191
183	MFW, Chest/Abd/Col/Lim	4326		193		Y	N	57
184	MFW, Abd/Ch/Pel/Col/Bla	382		16		Y	N	61
185	MFW. Abdom/Chest/Organs	392	196	15	7	Y	N	97
186	MFW, Skin/Tissue/NonPen	858		37		Y	Y	
187	Immersion Foot, Severe	91		15		N	N	39
188	Immersion Foot, Mod							
189	Chilblains, Mod							
190	Frostbite, Severe	116		19		N	N	88
191	Frostbite, Mod	658		110		N	Y	
192	Hypothermia, Severe	123		20		N	Y	
193	Heat Stroke	11		2		N	N	21
194	Heat Exhaustion							
195	Heat Cramps, Mod							
196	Appendicitis, Severe	38		6		Y	N	40
197	Appendicitis, Mod	154		26		Y	Y	
198	Inguinal Hernia, Severe	101		17		Y	N	41
199	Inguinal Hernia, Mod	903		151		Y	Y	
200	Torn Meniscus/Knee, Mod	235		37		Y	Y	
201	Lumbosacral Strain, Mod							
202	Eczema, Severe	6		2		N	Y	
203	Eczema, Mod							
204	Boils, Severe	188		27		Y	Y	
205	Boils, Mod							
206	Cellulitis, Mod	885		147		N	Y	
207	Dermatophytosis, Severe							
208	Dermatophytosis, Mod	628		99		N	Y	
209	Dermatophytosis, Mod							
210	Pediculosis, Mod							
211	Scabies, Mod							
212	Pilonial Cyst/Abscess	455		76		Y	Y	
213	Pilonial Cyst, Mod	411		59		Y	Y	
214	Ingrown Toenails, Severe	43		7		Y	Y	
215	Ingrown Toenails, Mod							
216	Herpes Simplex, Mod	3		1		N	Y	
217	Herpes Zoster, Severe	6		1		N	Y	
218	Herpes Zoster, Mod	18		3		N	Y	
219	Hyperhydrosis, Mod	192		31		N	Y	
220	Blepharitis, Mod							
221	Conjunctivitis, Severe	63		13		N	Y	

222	Conjunctivitis, Mod					
223	Corneal Ulcer/Abrasion	129	22	N	Y	
224	Corneal Ulcer/Abr, Mod	208	38	N	Y	
225	Iridocyclitis, Acute	46	8	N	N	114
226	Iridocyclitis, Mod	30	5	N	Y	
227	Refraction/Accomo, Sev					
228	Refraction/Accomo, Mod					
229	Otitis Externa, Mod	225	39	N	Y	
230	Otitis Media, Mod	409	60	N	Y	
231	Mastoiditis, Chronic	4	2	N	Y	
232	Allergic Rhinitis					
233	Upper Respiratory Infec					
234	Bronchitis, Acute	1138	195	N	Y	
235	Asthma, Severe	242	40	N	N	59
236	Asthma, Mod					
237	Influenza, Severe	321	54	N	Y	
238	Influenza, Mod	32	3	N	Y	
239	Viral Pneumonia, Severe	578	97	N	Y	
240	Viral Pneumonia, Mod	192	32	N	Y	
241	Bacterial Pneumonia, Sev	42	7	N	Y	
242	Bacterial Pneumonia, Mod	129	22	N	Y	
243	Food Poisoning, Severe	138	21	N	Y	
244	Food Poisoning, Mod					
245	Bacillary Dysentery, Mod	42	7	N	Y	
246	Enteritis/Diarrheal Dis	3480	574	N	Y	
247	Amebis Dysentery, Mod	30	5	N	Y	
248	Gastrits, Acute	318	56	N	Y	
249	Peptic Ulcer, Severe	26	4	Y	N	54
250	Peptic Ulcer, Mod	141	23	N	Y	
251	Regional Ileitis	38	6	N	N	61
252	Regional Ileitis, Mod	147	24	N	Y	
253	Helminthiasis, Severe					
254	Helminthiasis, Mod					
255	Migraine, acute					
256	Varicosities, Severe	2413	404	Y	Y	
257	Varicosities, Mod					
258	Essential Hypertension	379	55	N	Y	
259	Ischemic Heart Disease	19	3	N	N	70
260	Phlebitis, Severe	67	11	N	N	58
261	Phlebitis, Mod					
262	Tenosynovitis, Mod					
263	Meningococcal Meningitis					61
264	Meningococcal Meningitis					
265	Meningitis, Aseptic	63	11	N	Y	
266	Fever of Unknown Origen	343	57	N	Y	
267	Syphilis, Mod					
268	Gonorrhoea, Mod					
269	Non-specific Urethritis					
270	Chancroid	319	53	N	Y	
271	Lyphogranuloma Venereum	85	14	N	Y	
272	Glomerulonephritis, Mod	4	1	N	Y	
273	Glomerulonephritis, Chr	12	2	N	N	61

274	Pyelonephritis, Severe	26	4	Y	Y	
275	Pyelonephritis, Mod	6	1	N	Y	
276	Nephrotic Syndrome	6	1	N	N	61
277	Ureteric Calculus, Severe	16	3	YGH	Y	
278	Ureteric Calculus, Mod	150	25	N	Y	
279	Cystitis, Mod	550	92	N	Y	
280	Balanoposthitis, Mod	296	57	N	Y	
281	Mumps, Mod	137	23	N	Y	
282	Mononucleosis, Mod	533	89	N	Y	
283	Hepatitis, Infectious	412	69	N	Y	
284	Cholecystitis, Severe	10	2	Y	N	55
285	Cholecystitis, Mod	50	7	YGH	N	39
286	Pancreatitis Acute, Sev	184	31	N	N	30
287	Cirrhosis, Severe	2	1	YGH	N	84
288	Cirrhosis, Mod	4	1	N	N	61
289	Neoplasms, Severe	10	2	YGH	N	88
290	Neoplasms, Benign	34	5	Y	Y	
291	Menstruation Disorders	463	77	Y	Y	
292	Menstruation Dis, Mod					
293	Salpingitis, Mod	493	83	N	Y	
294	Cervicitis, Mod					
295	Vulovaginitis, Mod	367	62	N	Y	
296	Abortion, Legal					
297	Tubal Pregnancy, Severe	2	1	YGH	Y	
298	Tubal Pragnancy, Mod	4	1	YGH	Y	
299	Abortion, Spontaneous	6	1	YGH	Y	
300	Pregnancy, Uncomplicated	52	9	N	N	1
301	Psychosis, Severe	374	63	N	N	90
302	Conduct Disorders	80	16	N	Y	
303	Psychophysiologic Disor	17	1	N	Y	
304	Stress Reaction, Severe	885	148	N	Y	
305	Stress Reaction, Severe	885	148	N	Y	
306	Alcohol Dependency	799	139	N	Y	
307	Alcohol Misuse					
308	Drug Dependency	1441	241	N	Y	
309	Drug Misuse					
310	Stress Reaction, Temp					
311	Eye Wound, Severe	701	47	Y	N	63
312	Knee Wound	45	3	Y	N	34
313	Abdom/Kidney Wound	29	2	Y	N	40
314	Stress Reaction, Severe	885	148	N	Y	
315	Stress Reaction, Chronic	885	148	N	N	60
316	Alcohol Dependency, Sev	576	96	N	N	19
317	Drug Misuse, Severe	1441	241	N	Y	
318	Stress Reaction, Severe					
319	Hand Fracture/Wound	1668	76	Y	N	39

SUMMARY

20 Division NATO Force - 30 Days - Approximately 780,000 Combat Soldiers

Total Evacuation Category Patients Admitted - 78,466 Mean = 2615.53/Day
Minimum/Day = 2525 Maximum/Day = 2710

Total RTD Category Patients Admitted - III - 35,582 Mean = 1186.07/Day
Minimum/Day = 1144 Maximum/Day = 1253

Total Direct Admissions to Echelon IV - 9,317 Mean = 310.57/Day
Total Echelon IV Patients to be Evacuated- 4,150

Total Admissions to Echelons III and IV - 123,365

Total Died in Hospital - Echelon III - 780

Total Died in Hospital - Echelon IV - 23

HOSPITAL SUMMARY

This summary uses the three-type hospital system which is currently under review and which will probably be revised. Therefore it is of questionable value in projecting requirements for religious support.

Evacuation Hospital Beds Occupied
Mean = 8993.03
Average Stay = 2 Days
Minimum Stay = 1 Day
Maximum Stay = 15 Days

Combat Support Hospital Beds Occupied
Mean = 5126.17
Average Stay = 4.32 Days
Minimum Stay = 1 Day
Maximum Stay = 15 Days

General Hospital Beds Occupied
Mean = 10,904.83
Average Stay = 3.28 Days
Minimum Stay = 1 Day
Maximum Stay = 30 Days

Holding Company Cots Occupied
Mean = 10,927.70
Average Stay = 9.21 Days
Minimum Stay = 1 Day
Maximum Stay = 30 Days

PATIENT CLASSIFICATION SUMMARY

PATIENT CATEGORY DESCRIPTION	ADMISSION LEVEL	HOSPITAL	NUMBER
Stress Casualties	III	EVAC CSH	3540
	IV	GH	592
Neuropsychiatric Casualties - Non RTD	III	EVAC CSH	1835
- RTD	III	EVAC CSH	6433
- Non RTD	IV	GH	307
- RTD	IV	GH	1082
Amputees	III	EVAC CSH	7346
	IV	GH	741
Burn Casualties - Severe	III	EVAC CSH	2339
- Moderate	III	EVAC CSH	1933
- Severe	IV	GH	154
- Moderate	IV	GH	130
Surgical Patients	III	EVAC	74,095
	III	CSH	11,172
	IV	GH	4,826
Multiple Fragment Wound Patients	III	EVAC	28,448
	III	CSH	858
	IV	GH	1,270
Unconscious Patients	III	EVAC	9,591
	III	CSH	1,252
	IV	GH	522

Ambulatory - RTD = 26.7%
NRTD = 23.3%

Non-Ambulatory = 50%

Life Threatening Conditons = 18%

Permanent Disabilities = 18.1%

The data base provides the following statistics:

Deaths - Echelon 3 - 780
Echelon 4 - 23

Casualties who will be evacuated to Echelon 5 - Echelon 3 - 78,466
Echelon 4 - 4,150

Stress Casualties Treated - Echelon 3 - 3540
Echelon 4 - 592

Neuropsychiatric Casualties Treated - Echelon 3 = 1835 (To be evac)
6433 (RTD)
Echelon 4 = 307 (To be evac)
1082

Amputees Treated - Echelon 3 = 7346
Echelon 4 = 741

Burn Casualties Treated - Echelon 3 = 2339 (Severe)
1933 (Mod)
Echelon 4 = 154 (Severe)
130 (Mod)

Surgical Candidates Among Casualties - Evacuation Hosp = 74,095
Combat Support = 11,172
General Hospital= 4,826

Multiple Fragment Wounds - Evacuation Hospital = 28,448
Combat Support Hosp = 858
General Hospital = 1,270

Unconscious Casualties - Evacuation Hospital = 9,591
Combat Support Hosp = 1,252
General Hospital = 522

Total Evacuation Category Casualties = 78,466
Mean = 2615.53 per Day

Total Return to Duty Category Casualties = 35,582
Mean = 1186.07 per Day

Total Casualties Direct Admission to Level 4 =9,317
Mean = 310.57 per Day

Total Evacuation Hospital Beds Occupied
Mean = 8993.03
Average Stay = 3.47 Days
Min = 2 Days Max = 7 Days

Total Combat Support Hospital Beds Occupied
Mean = 5126.17
Average Stay = 4.32 Days
Min = 1 Day Max = 15 Days

Total General Hospital Beds Occupied
Mean = 9482.43
Average Stay = 3.82 Days
Min = 1 Day Max = 30 Days

Total Holding Company Cots Occupied
Mean = 10927.70
Average Stay = 9.21 Days
Min = 1 Day Max = 29 Days

Admitted to Echelon 3 and Echelon 4 Hospitals - 30 Days
Total = 123,365
Mean per Day = 4112.17

Echelon 2 Projected Deaths by Patient Classification
(according to CZAR model)

3	Cerebral Contusion	5%
5	Cerebral Contusion	10
7	Cerebral Contusion	4
9	Cerebral Contusion	4
11	Intracranial Hemorrhage	
17	Face Wound	1
19	Face Wound	1
29	Spine Fracture, cord damage	3
39	Head/Neck Burn, Severe	1
79	Upper Extremity Burn 10%+	1
83	Lung Injury, Severe	2
87	Thorax Wound, Resp Distress, Sev	2
92	Trunk Burn 20%+	1
94	Trunk Burn 20%+	2
98	Liver Wound, Severe	1
100	Spleen Wound, Severe	1
101	Abdomen Wound, Severe	5
102	Abdominal Wound, Mod	5
103	Abdomen/Liver Wound, Severe	5
104	Abdominal Wound, Moderate	5
105	Abdomen/Spleen Wound, Severe	8
106	Abdomen/Kidney Wound, Severe	5
108	Abdomen/Bladder Wound, Severe	3
120	Femur Fracture, Severe	1
123	Thigh Wound, Limb Not Salvage	1
147	Above Knee Amputation	2
159	MFW, Brain/Chest	10
160	MFW, Brain/Abdomin	7
161	MFW, Brain/Abdomin/Kidney	7
162	MFW, Brain/Abdomin/Bladder	6
163	MFW, Brain/Abdomin/Spleen	10
164	MFW, Brain/Abdomin/Liver	7
165	MFW, Brain/Lower Limbs Amputation	5
166	MFW, Chest/Abdomin/Colon	6
167	MFW, Chest/Abdomin/Kidney	5
168	MFW, Chest/Abdomin/Bladder	4
169	MFW, Chest/Abdomin/Spleen	8
170	MFW, Chest/Abdomin/Liver	5
171	MFW, Chest/Limbs/Vascular	2
172	MFW, Abdomen/Colon/Bladder	6
173	MFW, Abdomen/Colon/Spleen	10
174	MFW, Abdomen/Colon/Liver	7
175	MFW, Abdomen/Colon/Limbs	6
176	MFW, Abdomen/Pelvis/Kidney/Liver	7
177	MFW, Abdomen/Pelvis/Spleen/Blad	9
178	MFW, Abdomen/Pelvis/Kidney/Limbs	5
179	MFW, Abdomen/Pelvis/Bladder/Limbs	4
180	MFW, Abdomen/Spleen/Limbs	8
181	MFW, Abdomen/Liver/Limbs	5

182	MFW, Brain/Chest/Limbs	5
183	MFW, Chest/Abdomen/Colon/Limbs	6
184	MFW, Abdom/Chest/Pelv/Colon?Blad	17
185	MFW, Abdomen/Chest/Major Organs	16
192	Hypothermia	2
259	Ischemic and Other Heart Disease	5

Other Data From Data Base

Intratheater Evacuation - 30 Days
Mean = 2589.53
Min = 2433 Max = 2666
Total = 77,686

Intertheater Evacuation - 30 Days
Mean =2727.37
Min = 2627 Max = 2840

Category	Daily Average	Total	Percentage
Medical	50.73	1522	1.86
General Surgery	204.43	6133	7.50
Neurosurgery	381.63	11449	13.99
Urology	15.60	486	0.57
Burns	121.43	3643	4.45
Thoracic Surgery	456.07	13214	16.72
Psychiatric	49.00	1470	1.80
Orthopedic	1240.47	37214	45.48
Oral/Maxillo Facial	117.40	3522	4.30
Ophthamology	68.27	2048	2.50
Spinal Cord Injury	22.33	670	0.82
TOTALS	2727.37	81821	100.00

Combat Zone Return To Duty
Mean = 1186.07
Min = 1079 Max = 1256
Total = 35,582

Communication Zone Return To Duty
Mean = 171.97
Min = 143 Max = 203
Total = 5,159

CONUS Return To Duty - From 61 Days to 450 Days
Mean = 27,022.5 per 15 Days
Min = 23195 Max = 30438
Total = 471,475

LONG TERM HOSPITALIZATION

No of Days	No of Patient Cat	Total No	Percentage
31-60	65	20,978	26.7%
61-90	53	26,883	34.2
91-120	10	6,804	8.7
121-150	11	7,047	9.0
151-180	6	7,309	9.3
181-210	2	3,461	4.4
211-240	1	121	0.15
241-270			
271-300	5	5,665	7.2
301-330			
331-360			
480-510	3	273	0.35

SURVEY DATA

Vietnam Surgical, Field, and Evacuation Hospital Chaplains

Conducted beginning 12 March 1985

33 Chaplains Contacted - 7 Chaplains Responding

Surgical Hosps - 2 Field Hosps - 2 Evacuation Hosps - 2

Not Identified - 1

1) Eastern Orthodox - 93rd Evacuation Hospital - Long Binh
2) Southern Baptist - 18th Surgical Hospital - Lai Khe
3) Not identified - 3rd Surgical Hospital - Dong Tam
4) Not identified
5) Conserv. Congregational Christian - 3rd Field Hosp - Binh Thuy
6) United Methodist - 3rd Field Hospital - Tan Son Nhut
7) Roman Catholic - 95th Evacuation Hospital - Da Nang

1. What religious acts did the soldier/patient request from you?

1) Religious services, special sacraments, reassuring counseling
2) Prayer, communion, worship, baptism (in order)
3) Comfort, empathy, assurance, presence, prayer, sacraments
4) Prayer, communion, Bible(rel lit), acts of comfort
5) Communion, baptism, prayer
6) Prayers, communion, baptism
7) Communion, prayer books, rosaries, medals, confessions, counseling, spiritual direction, presence, prayer, anointing, Viaticum - One asked to accompany into surgery

2. What religious acts did the chaplain offer the patients?

1) Counseling and religious rites
2) Pastoral counseling, sympathetic listening ear, prayer, communion, baptism(not done 5 or 6 requests), worship
3) Presence, holding hand, reciting Bible passages which promise God's presence, prayer
4) Prayer, communion, Bible(rel lit), Acts of comfort
5) Communion, baptism, prayer, Scripture reading
6) Prayer, communion
7) Rites, ceremonies, counseling, sometime preceded by instruction if marginal contact with Church

3. What secondary functions did chaplain perform in emergencies?

1) Seldom tasks other than MOS
2) Occasionally helped litter bearers, not often

3) Assist litter bearers, cut off boots, uniforms, restrain-panic stricken, "never...being involved in medical treatment" or "running errands for medical personnel"
4) Yes, all areas in question
5) Yes, to all
6) Not at my hospital
7) Not on wards, in emergency room - restraining struggling patients, holding pressure to stem bleeding, lifting or transferring patients, extra pair of hands to get suture sets, clamps, etc.

4. Was counseling performed to the following situations?

a. soldier with limb loss 1)third 2)yes3rd 3)yes 4)third 5)yes 6)yes, acceptance most difficult 7)no
b. soldier blinded 1)second 2)yes2nd 3)no 4)no 5)yes 6)no 7)yes 1 only
c. soldier expectant to die 1)second 2)yes 3)yes1st 4)first 5)yes 6) 7)yes
d. soldier unwilling to return to duty 1)first 2)no 3) 4)second 5)yes 6)threat to self in combat 7)yes2
e. soldier with loss of buddy 1)third 2)yes4th 3) 4) 5)yes 6)yes 7)yes with staff
f. soldier with pain and no available medication 1)first 2)yes5th 3) 4) 5)yes 6) 7)
g. other 4)helped prepare patient for pending surgery 5)soldiers with self inflicted wounds, moral turpitude problems, marriage problems 6) general concerns 7)drug abuse counseling

5. What was the function of the chaplain in a mass casualty sit?

1) comfort those about to die, confront those not in immediate life threatening danger
2) moved among wounded, praying, talking with them, sitting in silence, touch on shoulder or injured part of body, presence which relieved anxiety, answered simple questions notified staff about one patient in crisis who had seemingly minor wound, but could not breathe
3) a little of everything, see Q 3
4) comfort the wounded and assist in any manner that might bring healing to the greatest number
5) worked with medical staff but gave priority to dying soldiers
6) make self available to those who needed him, prayer and concern
7) last rites, carrying stretchers, staying with agitated patients

6. Descriptions of moral and ethical issues in patient care

1) no conflict seen
2) No, but one incident in which patient was kept 14 days rather than the 3 days because doctor was interested in his particular surgical condition
3) No, but were problems of a moral and ethical nature of the medical staff
4) Yes, medical personnel needed to be reassured plus they required the chaplain to symbolize the moral and ethical conscience involved in healing ministry
5) None, but had to confront some other issues of morality
6) No such problems
7) Staff and command interaction in caring for Vietcong and North Vietnamese wounded, handled well, some problems of obscene humor addressed

7. Was the manning level for chaplains adequate? Recommend?

1) Not adequate, 1 Ch/100 beds
2) Not adequate for around the clock coverage, which was needed in surgical hospital, adequate for number of beds
3) Adequate for small hospital
4) Yes and no, Chaplain needs to be aware of other resources to call upon if needed
5) 1 Ch/75 beds, 2 Ch/76-200 beds, 3 Ch/201-300 beds, and 1 additional Ch for each additional 100 beds
6) 2 Ch for 340 beds in facility were adequate
7) Adequate, but needed back up at times for R & R, meetings and an occasional day off, 24 hour coverage provided

8. Did a shortage of chaplains restrict your ministry?

1) Yes, spent less time visiting all the patients
2) Need 2 chaplains for day and night coverage, also Prot. and Catholic
3) No shortage
4) Restricted - yes, shortage - no. Often had to choose areas of ministry at the expense of other vital interests and/or pastoral concerns
5) No
6) No, but casualties were light during tour
7) Refer to answer to Q 7

9. Describe the needs of medical staff for pastoral care.

1) fatigue, overwork, excessive casualties (order)
2) boredom,excessivecasualties,overwork,stress management, fatigue, grief therapy, overexposure to wounded (order)

3) stressmanagement, fatigue,overwork,excessive casualties = yes; overexposure to wounded, boredom, grief therapy = no
4) stress management stands out, includes overworked, grief, and fatigue - staff often unwilling to admit "need"
5) all, dealing with 'MASH' syndrome, personal problems, spiritual concerns, Bible studies
6) morale was high except in renal unit, which had a 75% death rate
7) chaplain and psychiatrist worked together, drug abuse problems in hospital, also problems in spouses of different ranks being assigned together

10. Hospital ministry viewed as a sacramental or counseling ministry?

1) Counseling
2) Counseling
3) Sacramental, counseling for staff
4) Sacramental
5) Counseling (from my background, what else?)
6) Counseling
7) Sacramental

11. In what areas was a hospital chaplain least effective?

1) pointing out doctors' faults and inadequacies
2) incommunicatingthevalueofpastoralcounseling, pastoral care, and ministry of presence (followed a chaplain who was a "goffer")
3) chaplain in the way in the heat of action during mass casualties and chaos situations
4) administration
5) time management
6)
7) difficult to resolve infighting, especially in nursing section

12. Was chaplain regarded as member of medical healing team? Were consults written to chaplain as a matter of SOP?

1) Yes, consults were written, not part of SOP
2) Finally, after first six months
3) Yes, no to consults question
4) Only after weeks or months of having to prove self
5) Yes, not at first. Consults, yes, later on
6) By some, not part of SOP
7) Yes, accepted, verbal consults were asked

13. Did you perceive soldiers' religious needs to be over and above denominational requirements?

1) Yes
2) Yes
3) Never
4) By all means
5) Yes, but denominational needs important also
6) Needs were overwhelmingly individual rather than denominational
7) All patients visited daily by either Protestant or Catholic chaplain, denominational requests were responded to by the appropriate chaplain

14. Was there a problem providing Catholic coverage in the hosp?

1) No
2) No, nearby Air Force Catholic chaplain provided masses
3) No, but Jewish coverage was a problem
4) No, one did what one could
5) No
6)
7) No, "I was a Catholic chaplain"

15. What was your experience with the triage of patients?

1) a painful but necessary procedure for all staff members
2) See responses to Q 5 & 7 above
3) appearances were not always an accurate gauge for the triage concept, sometimes it didn't work to save lives
4) ministry of presence plus do anything to save and preserve lives, ritual became secondary
5) sense of helplessness
6) low casualties did not make this a real problem
7) limited, we had very few "mass" casualties

16. Were support groups, formal or informal, developed among staff?

1) informally, with chaplain playing a leading role
2) Yes, led an informal group on personality conflicts, stress, maladjustments, listening to doctors complain
3) None
4) Yes, both formal and informal under chaplain leadership
5) informal, chaplain providing leadership at times
6) No
7) club was a focal point

17. What mechanisms were used by staff members in handling/coping with their feelings in addressing the impact of casualties upon themselves?

1) Practices of faith, athletic and social activities
2) Some cried, drank heavily, played poker, cursed the system busied themselves with busyness
3) staff meetings, talking with chaplain about feelings
4) cry for help for patients or other staff members as way of seeking resources to meet their own needs
5) booze, jokes and twisted humor, participation in religious services
6) one withdrew, others did job as best they could
7) informal, chaplain and psychiatrist helping

18. What mechanism did the chaplain use in coping with the impact of casualties upon his feelings?

1) Intense prayer and social work among Vietnamese
2) Talked with some of the nurses and other staff, not often with other chaplains who seemed to have no needs. Seemed like only one in system with needs and weaknesses
3) Prayer, meditation, seeking out chaplains of other units, chaplain supervisor
4) As a confidant or significant other
5) Prayer, shouting at God, another chaplain to share the hurt with
6) Only one severe situation requiring ministerial contact, sedation, and evacuation
7) Network of chaplains in area, also monthly Catholic Day of Recollection

19. What adaptive behavior to situational stress did the chaplain observe which could be addressed by pastoral care to the staff in the future?

1) Boredom and alcohol
2)
3) Problems relating from alcohol and guilt from promiscuity, e.g. adultery among doctors and nurses
4) See Q 17
5) Indifference, denial, repression, anger
6)
7) Caring for children at orphanages was helpful release

20. What stresses did the hospital chaplain have to deal with among the staff?

1) Grief, disregard, insensitivity, repetitiveness of torn bodies, loneliness

2) Repetiveness of torn bodies, grief, loneliness, insensitivity, disregard - administrators were insensitive, but not in direct contact with patients
3) Loneliness, disregard, repetiveness of torn bodies, grief
4) Grief, repetiveness of torn bodies, insensitivity
5) Loneliness, grief, rage
6) Sense of futility
7) Lonelienss and inappropriate "intimate" relationships among staff

21. What was the role of the chaplain with the expectant category of patients whom the staff "knew" were going to die?

1) Chaplain was primary source of comfort
2) Make self available, informed by chief nurse of expectant
3) Called a priest if Catholic, "I was always consulted and did whatever I could to bring comfort"
4) To insure that the patient was still regarded as a medical concern and a human concern
5) Was always notified of these and was expected to be with the dying
6) Frequent visitation and prayer
7) Called for "last rites," took time to stay with the patient, dealt with staff's feelings of grief and loss

22. In hindsight what would you have done differently?

1) Would seek way of spending more time with medical staff
2) I don't know
3) Nothing different. In a dying situation, as a Protestant, I often wished I had something to do in terms of anointing or pronouncing a liturgy of some kind, as my priest friends did
4) Nothing
5) Would take more time for personal physical fitness
6)
7) After CPE training after Vietnam, would have done differently, just by being more aware of what I was doing

23. Is it beneficial for the chaplain to have psychological training?

1) Yes
2) Definitely, 4 quarters of CPE were a definite assist
3) Definitely
4) It might be helpful, but one need not make him/her a psychologist
5) Yes
6) Very, "I felt inadequate"
7) See Q 22

24. Do you perceive the increased number of females in the hospital staff today to present a potential stress management problem...?

1) No
2) Possibly, if in moving to the front all female nurses are replaced by males. I doubt that there will be any more stress management problems
3) Yes, but I'm not sure in what way. Relationships would be involved
4) The stress management problems reach beyond the confines of the sexes or previous battle experience
5) Yes, this is certainly a political issue. Faced honestly, the females as a group are good workers, females in a war oriented environment are stressors for males
6) Were a blessing in hospital, both as professionals and as women. More would be of similar value
7) Chauvinistic attitudes will die a very hard deathamong the old "brown shoe" Army. Army Nurse Corps leadership cannot lose sensitivity for married nurses.

25. What ministry did you perform wherein you felt you provided a most meaningful contribution?

1) In strengthening the faith of those who had some, and in witnessing to those that had none
2) Being present with the wounded and dying, offering prayer and ministry of presence, pastoral relationships with staff sharing concerns, conducting worship and devotionals
3) Being there, not above the action but right in the middle... representing God to lonely, frightened young boys in desperate conditions. It was providing whatever was necessary to be a comfort and assurance to soldiers. A ministry of presence, almost as important as what I did
4) I was the bridge that patients and staff alike could call upon to shorten the gap between shameful past and dreaded future. The chaplain became the vehicle of grace and forgiveness
5) Bible studies and pastoral counseling
6) Counseling patients and relating in a supportive way to hospital personnel
7) See other answers

SURVEY DATA

Division Chaplains

Conducted beginning 18 January 1985

10 Division Chaplains Responding

Applicable questions for Religious Support to Casualties' Study

6a. How will chaplains in division provide casualty care coverage?

1) Unit, aid station
2) FEBA, aid station
3) Brigade, Forward Support Battalion Clearing Station
4) Field hospital
5) Far forward, battalion aid station
6) Battalion aid station
7) Battalion aid station
8) Battalion aid station
9) Battalion aid station
10) No response

6b. 6c. Have points been identified throughout the division medical chain where casualties are expected to die? Which points?

1) No 2) BAS 3) No 4) No 5) No 6) No 7) BAS 8) BAS
9) Yes 10)

7. How do you as senior chaplain foresee utilization of the 71M with casualty care?

1) Support chaplain
2) Support chaplain
3) Screening for chaplain, listing priorities
4) None, chaplain assistant is not in the casualty care business
5) Identify critical casualties
6) Stress management
7) Medic, stress management
8) Triage
9) Casualty monitor at the battalion aid station
10) Identify and locate casualties

9. If deployed today, what ministerial acts would be performed for the casualty?

1) Traditional
2) Last rites, prayer, Scripture

3) Rites, prayer, confession
4) Rites
5) Comfort, presence
6) No response
7) Rites
8) Casualty driven
9) Anointing, prayer, memorial services/ceremonies
10) Rites

11. A Unit Ministry Team encounters a life/death situation at either the point of wounding or in the battalion aid station. No medic, physician assistant, physician, or nurse is available. Which of the following actions do you prefer?

a) pray with the WIA
b) go for medical aid
c) your suggestion
d) perform first aid on the WIA to include, as needed:
   (a) clear the airway of the conscious victim
   (b) perform rescue breathing
   (c) manage the airway
   (d) perform one man CPR
   (e) apply a pressure dressing for bleeding
   (f) apply a tourniquet
   (g) treat for shock
   (h) initiate and maintain an IV
   (i) splint a suspected fracture
   (j) manage combat stress reactions
   (k) initiate first aid for burns, or heat injury, or cold injury
   (l) restore breathing in a chemical casualty

1) First aid
2) Life saving
3) First aid, go for medic
4) all - pray, go for medical aid, first aid
5) Go for medic
6) First aid, go for medic, pray
7) First aid
8) First aid, go for medic
9) First aid
10) First aid

11b. Are your chaplains proficient and/or experientially familiar with the above combat lifesaver tasks/skills?

1) Yes 2) Yes 3) No 4) Yes 5) No 6) No 7) No 8) Yes
9) Yes 10) Yes

11c. Would you recommend the UMT have familiarization with life-saver skills?

All responded Yes

14. During FTXs, do your chaplains perform casualty play with aid stations?

1) Yes 2) No 3) No 4) Yes 5) No 6) No 7) Yes 8) Yes
9) Yes 10) Yes

15. Do chaplains have an active role in advocating wellness?

1) No 2) Yes 3) 4) Yes 5) No 6) No 7) Yes 8) Yes
9) Yes 10) Yes

17. Have your chaplains addressed their own vulnerability and exposure to injury in combat?

1) No 2) Yes 3) Yes 4) No 5) No 6) No 7) 50/50 8) Yes
9) Yes 10)

17b. Have chaplains addressed contingency plans for remaining with casualties in the event of enemy advance?

1) 2) Yes 3) Yes 4) No 5) No 6) No 7) No 8) Yes
9) Yes 10)

19. What is the greatest need in your unit to provide chaplain support to casualties?

1) Commo
2) Time
3) Transportation
4) More chaplains
5) Training
6) Teachable chaplain assistants
7) No response
8) Update casualty triage
9) Training
10) Personal experience in first aid, knowledge of medical operations

22. What contingency plans do division chaplains have to cover casualties if their traditional freedom of movement by vehicle is restricted on the AirLand battlefield?

1) None
2) Yes
3) Independent action
4) Area coverage
5) No vehicle

6) Unintelligible response
7) None
8) Move with battle force
9) Movement
10)

SUBSTANTIVE APPENDIX E

DOCTRINE SUMMARY

AIRLAND BATTLE

The Army's basic fighting doctrine, as described in FM 100-5, is AirLand Battle. Its four basic tenets are: initiative, agility, depth, and synchronization.

Initiative is setting or changing the terms of battle by action. Agility is the ability of friendly forces to act faster than the enemy. Depth is the extension of operations in space, time, and resources. Synchronization is the arrangement of battlefield activities to produce maximum relative combat power at the decisive point.

Ten imperatives prescribe the key operating requirements of the AirLand Battle. They are:

- Ensure unity of effort
- Anticipate events on the battlefield
- Concentrate combat power against enemy vulnerabilities
- Designate, sustain, and shift the main effort
- Press the fight
- Move fast, strike hard, and finish rapidly
- Use terrain, weather, deception, and operations security (OPSEC)
- Conserve the strength for decisive action
- Combine arms and sister services to complement and reinforce
- Understand the effects of battle on soldiers, units, and leaders

Offensive operations are characterized by surprise, concentration, speed, flexibility, and audacity. Defensive operations are characterized by preparation, disruption, concentration, and flexibility.

AirLand Battle is extended, continuous, and integrated. It is extended from the FLOT forward as enemy second echelon forces are engaged. It is extended from the FLOT rearward as enemy penetrations into friendly rear areas are fought. It is continuous as the battle is fought both day and night for extended periods. It is integrated as all available air and land forces, combining conventional, NBC, and directed energy weapons, are used to fight the battle.

HEALTH SERVICE SUPPORT, AIRLAND BATTLE (HSSALB)

The Army Medical Department's emerging doctrine to support the AirLand Battle is Health Service Support, AirLand Battle (HSSALB). Its basic tenets are:

- Health Service support as a continuum from FLOT thru CONUS
- Prevention
- System designed to optimize return to duty (RTD)
- Modular Medical Support at NATO Echelons I and II
- Immediate far forward care
- Rapid and responsive evacuation with air/ground evacuation assets controlled and integrated as a system
- System which is designed for war and modified for peace
- Mobility that is in accord with AirLand Battle tenets
- Provide for rapid and responsive evacuation
- Dedicated aircraft for aeromedical evacuation

Other major tenets of HSSALB are:

- Enhanced ancillary and functional support systems with advanced technologies
- Medical system that provides continuous medical management throughout all levels/echelons of care and evacuation (White Paper, HSSALB in the Corps and COMMZ, 26 November 1986)

Recent HSSALB policy changes include:

- Evacuation policy
  7 days in CZ
  30 days in COMMZ
- No selectivity by organizational design/specialty orientation
- Selectivity (RTD/NRTD) at Echelon III rather than Echelon II
- Echelon III hospitals capable of providing initial care to all classes of patients
- Improved deployability
- Increased far forward surgical capability
- Increased surgical capability for advanced deployment and/or contingencies

The principles of Health Service Support Operations are conformity, continuity, control, proximity, flexibility, and mobility.

Conformity is planning and organizing health service support to fit the commander's tactical plan of operations.

Continuity is providing a continuum of care, optimizing resource utilization and maintaining the physiology of patients as they are transported between medical treatment facilities.

Control is centralized with decentralized execution. This permits rapid tailoring of austere health service assets to respond to major shifts in the location and volume of casualties, changes in supported unit composition, and changes in the intensity of the conflict.

Proximity, as dictated by mission, enemy, terrain, troops, and time available (METT-T) factors, is far forward treatment and stabilization of casualties, early identification and forward treatment of RTD category patients, and forward orientation of evacuation resources.

Flexibility is rapidly placing, reinforcing, augmenting, and tailoring health service support to meet contingencies using medical modules.

Mobility is rapidly moving medical units to best support combat operations.

ECHELONS OF MEDICAL TREATMENT

Medical treatment is provided by echelons. Each echelon of care or treatment is contained within the capabilities of the next higher echelon. Individuals/elements organic to combat, combat support, and combat service support units provide Echelon I treatment/care. It is immediate far forward care consisting of first aid, initial medical treatment, and lifesaving steps that do not require the knowledge of a physician.

The objectives of Echelon I care are to return to duty soldiers whose injuries are not serious and to stabilize more seriously injured casualties for evacuation to the next higher level/echelon of care and treatment.

The three skill levels of Echelon I care are self-aid/buddy aid, combat lifesaver, and combat medic.

Self aid buddy aid is first aid to save lives, initial bandaging of wounds, and initial treatment of NBC casualties. Capabilities include maintaining an airway, stopping bleeding, and preventing shock.

Combat lifesavers assist combat medics as the tactical situation permits in providing enhanced first aid treatment including performing one man cardiac pulmonary resuscitation, initiating and maintaining an IV, and evaluating the casualty.

Combat medics provide the initial medical treatment, making medically substantiated decisions based upon medical military occupational specialty (MOS) specific training.

Treatment squads located at battalion level treatment locations augment Echelon I care. Organic physicians and physicians' assistants provide medical treatment, including advanced trauma life support (ATLS). Capabilities include insertion of breathing tubes, treatment for shock, initial burn treatment, and emergency trauma treatment.

NATO Echelon II medical care and treatment is provided at clearing stations in divisions and corps, where casualties are medically evaluated to determine priority for treatment and continued evacuation to the rear.

Medical personnel at these locations continue emergency trauma care, institute additional immediately necessary emergency measures, and retain casualties who can RTD in 1-3 days. Surgical teams/detachments may be deployed to this level to perform only emergency surgery necessary to save lives.

NATO Echelon III medical care and treatment is provided by Health Service Support, AirLand Battle hospitals. All hospitals are capable of treating all classes and categories of medical casualties.

Hospital units are structured in modular form which permits incremental increases or decreases to accommodate varied patient workloads. The hospital support system's flexibility and agility enables task orientation to support the AirLand Battle in varying scenarios.

Emerging doctrine proposes two Echelon III hospitals. They are a Surgical (MASH) type hospital and a Combat Support (CSH) type hospital.

The MASH type hospital provides resuscitative surgery and medical treatment necessary to prepare critically injured/wounded patients for further evacuation to definitive treatment facilities. It will have approximately 30 ICU beds and be austerely staffed.

The CSH type hospital provides resuscitative surgery and medical treatment necessary to prepare critically injured or ill patients for further evacuation, medical treatment for RTD category patients, and definitive treatment for all patients within limitations imposed by the evacuation policy and available health care services.

NATO Echelon IV hospitals are: the General Hospital (GH), Combat Support type hospitals deployed in the COMMZ, and holding type hospitals.

The General Hospital provides medical treatment of a definitive and specialized nature and studies of patients with serious or complicated illnesses, diseases, or injuries. It receives transfers from all other hospitals and provides required stabilizing treatment to casualties who cannot withstand evacuation to CONUS without further stabilization or definitive treatment.

NATO Echelon V hospitals are CONUS hospitals, including medical centers and other definitive treatment facilities.

MASS CASUALTIES

Health service support planning anticipates situations in which the number of casualties exceeds local health service support capabilities. The key factors for effective mass casualty management are on-site triage and emergency

care, effective communications, and skillful evacuation by ground and air resources.

Medical units, while maintaining safe standards of care, are prepared to alter the scope of medical treatment with the objective of providing the greatest good for the greatest number of patients while maximizing RTD.

The following principles are followed when planning for and supporting a mass casualty situation:

- Rapid reinforcement by mobile medical (treatment squads) and surgical teams/squads
- Rapid reinforcement of medical supplies
- Rapid replenishment and reinforcement of patient evacuation resources

EVACUATION

Patient evacuation is timely and efficient movement and enroute medical care of wounded, injured, or ill casualties from the battlefield and other locations to medical treatment facilities.

Evacuation begins at the point of injury or illness and continues as far rearward as the medical condition dictates or the military situation requires. Early identification of RTD and NRTD patients minimizes overevacuation and supports optimal use of evacuation resources.

Medical evacuation encompasses:

- Collecting the wounded for evacuation
- Sorting and triaging
- Providing an evacuation mode (transport)
- Providing medical care en route
- Anticipating complications, being ready and capable of performing required emergency interventions

The theater evacuation policy, as established by the Secretary of Defense, with the advice of the Joint Chiefs of Staff, and as recommended by the theater commander, is the number of days that patients can be retained in theater for treatment prior to return to duty. Patients are evacuated when treating physicians determine that transportation will not unnecessarily aggravate patients' disabilities or medical conditions.

Intratheater evacuation policy establishes the maximum numbers of days of allowable hospitalization in corps hospitals prior to either RTD or further evacuation within theater.

Evacuation delays (also called evacuation schedules) are the number of days after admission to a level/echelon that patients who have been identified for evacuation must wait before actually being evacuated. This time period is fixed and the same for all patients who are awaiting evacuation.

For an example, a 3-6 evacuation schedule would mean that all patients admitted would have 6 days to be stabilized and 3 days to be evacuated following admission. This evacuation delay is applied to all patients who are expected to exceed the evacuation policy. Those who do not exceed the evacuation policy will be retained until they can return to duty.

Evacuation assets are provided on an area basis in low intensity conflicts, primarily using air ambulances to evacuate both RTD and NRTD patients with any category of precedence (urgent, priority, and routine). Ground evacuation is used for local evacuation and for patients who cannot be moved by air.

Evacuation assets are provided by organic units and supporting medical companies and battalions in mid-high intensity conflicts. Maneuver units use organic ground evacuation assets to evacuate casualties from as far forward as possible to division level treatment facilities.

Air ambulances retained at corps provide reinforcing and reconstitution support to forward deployed companies and evacuation from division level to corps level medical facilities. Air ambulances also also provide evacuation support to the corps rear area and movement of patients between corps medical facilities.

During deep operations, ground ambulances evacuate casualties to ambulance exchange points (AXPs) for transfer to air ambulances. Air ambulances provide evacuation to air assault forces operations.

Airborne forces conducting deep operations receive unit and division ground evacuation from organic assets. Evacuation from airborne areas of operation are provided normally by Air Force assets. Organic ground assets of engaged or reserve forces provide evacuation support for rear operations. Corps air and ground evacuation assets reinforce organic assets during rear operations.

MEDICAL REGULATING

Medical regulating coordinates the movements of patients to the medical treatment facilities (MTFs) which are best able to provide timely and required care. Factors which affect scheduling include:

- Patient conditions (whether stabilized for evacuation and urgency for movement)
- Tactical situation
- Availability of evacuation means
- Location of treatment facilities with specificresources and capabilities
- Current bed status of treatment facilities
- Surgical backlogs
- Number and location of casualties by diagnostic category
- Location of airfields and seaports

EMPLOYMENT

The number and mix of hospitals depends upon the evacuation policy, the size of combat forces supported, and the availability of air medical evacuation assets.

In a low intensity conflict, the evacuation policy is short. Small mobile flexible hospitals with limited surgical and patient holding capabilities are needed. Initial deploying hospital elements may be portions of a CSH or other hospital. The number of in-country RTDs is small.

In a mid-high intensity conflict during the first 48 hours, all hospitals will receive all types of patients. The evacuation policy and the evacuation delay is short. Direct evacuation of casualties out of the Combat Zone may be necessary.

During days 3-20, medical units are deployed to decrease overevacuation, increase RTD within corps, and overcome shortages in surgical capability and bed capacity.

During days 20-30, the RTD capability is further increased and NRTD are channeled into an evacuation stream.

During days 30+, the maturation of theater permits an increase in the evacuation policy to no more than 30 days in corps. RTDs may be retained between 30 and 60 days in Echelon IV hospitals.

COMBAT STRESS CONTROL

Combat Stress Control is a coordinated program, administered by mental health personnel, which provides prevention and treatment resources for battle fatigue casualties. Its six major functions are consultation, neuropsychiatric triage, reconstitution support, restoration, reconditioning, and stabilization.

Consultation is advising and assisting commanders to screen soldiers unfit for duty, to monitor, control, and reduce stresses associated with deployment and combat, to conduct preventive programs, and to assist in reintegrating RTD stress casualties into their units.

Neuropsychiatric triage is diagnosing and sorting combat stress, neuropsychiatric, and alcohol and drug misuse casualties (including those with physical injuries) in order to recommend the best treatment at the lowest level so as to maximize return to duty.

Reconstitution support assists units rendered noneffective in combat when they are temporarily withdrawn for reconstitution and/or rest.

Restoration is treatment provided to combat stress casualties for 1-3 days at the lowest level that the tactical situation permits. Treatment consists of reassurance, rest, nutrition, and activities designed to restore confidence.

Reconditioning is a 5-21 day intensive program of nutrition, physical activity, therapy, and retraining provided in a corps nonhospital setting.

Stabilization manages acute battle fatigue, neuropsychiatric, and alcohol and drug misuse patients who have severe behavioral or medical disturbances. RTD potential is evaluated.

HSSALB policy is that neuropsychiatric, battle fatigue, and alcohol and drug misuse casualties are not hospitalized unless necessary for patient safety. Those requiring hospitalization are presumed to have RTD potential unless an accompanying medical or surgical diagnosis dictates further evacuation. NRTD psychiatric patients are treated at Echelon III and Echelon IV hospitals prior to evacuation to CONUS.

FUNCTIONAL SUPPORT SERVICES

Integrated into the Health Service Support, AirLand Battle system are 12 functional support services which are essential to providing total and efficient health care. Including those previously discussed, these are:

- Preventive medicine
- Dental services
- Combat stress control
- Veterinary services
- Medical logistics
- Area medical support
- Laboratory services
- Communications, command, control
- Evacuation and medical regulating
- Nutrition care services
- Occupational and physical therapy services
- Medical support in an NBC environment

Preventive medicine reduces the incidence of disease and nonbattle injury through providing preventive consultations and programs. Prevention of illness and disease is the most effective and least expensive means of providing the maximum number of healthy soldiers.

Preventive medicine operations are characterized by commander involvement, early deployment of preventive medicine elements, and preemptive actions to eliminate disease threats.

Dental services promote dental health, help prevent oral diseases, and provide treatment to eliminate or reduce the effect of dental injuries and disease.

Veterinary services provide inspection of food, monitor the incidence of zoonotic disease, and provide comprehensive medical care to military working dogs.

Laboratory services provide blood and blood products, basic laboratory tests and procedures, and in the COMMZ an augmented capacity to evaluate the total health environment of the theater.

Medical logistics provides medical supplies, biomedical equipment maintenance, optical fabrication, oxygen and resuscitative fluid production, and blood banking services.

The Medical Command, Medical Brigades, and Medical Groups provide command, control, and supervision for assigned and attached units in the theater Army.

BASIC UNIT MINISTRY TEAM DOCTRINE

Soldiers are entitled to the free exercise of their religious faith wherever they live, work, or fight. This right is guaranteed to all citizens by the First Ammendment of the Constitution and is limited only by the needs of the combat environment or the military unit's mission.

The commander is responsible for the religious, spiritual, moral, and ethical well-being of all military personnel within the command. The chaplain is the commander's staff officer, advisor, and consultant on matters pertaining to religious life, morals, and morale as affected by religion.

The primary mission of the Unit Ministry Team (UMT) is to provide religious support to soldiers in combat. In brief, the UMT's mission is three-fold:

To nurture the living
To care for the casualties
To honor the dead

Religious support is provided through pastoral ministry defined as supporting the spiritual life of the soldier. It is accomplished through conducting services, administering rites, visiting, comforting, and encouraging. UMTs minister to soldiers experiencing the shock, brutality, chaos, isolation, stress, dangers of disability and death, and the trauma of the modern battlefield.

The Army doctrine designed to provide effective religious support on the AirLand Battle is called Forward Thrust. Under this doctrine, religious support is pushed forward to smaller, more exposed elements of the task force. Personal contact increases in value to the soldier and unit as the battlefield increases in lethality and intensity. Ministry needs increase due to mass casualties, hasty burials, and isolation.

Forward Thrust doctrine requires assigning UMTs down to battalion and equivalent size units. Religious support is enhanced by sharing chaplain resources within an area of operations.

Ministry differs during the phases of battle. During the pre-battle phase, UMTs minister to soldiers experiencing anxiety, providing counseling, spiritual reassurance, and encouragement.

During the battle phase, the priority for religious support is to casualties. The UMT, depending on METT-T, may focus on the casualty collection points of the most heavily engaged units. At times the UMT may move about to minister rather than wait at a single casualty collection point.

During the post-battle phase, the priority for religious support is to stress and trauma casualties. During lulls, UMTs provide small group counseling and services. During withdrawals, UMTs minister to casualties who may be left behind, perhaps risking capture or death.

During reconstitution, the UMTs console the living, conduct intense individual and group counseling, and conduct brief services to honor the dead. As hostilities end, UMTs provide intensive pastoral care of both casualties and noncasualties and conduct more formal memorial services and honors for the dead.

RELIGIOUS SUPPORT TO CASUALTIES DOCTRINE

Religious support to casualties contributes to the total well-being of soldiers who are casualties and is essential to their quick return to health and duty. Religious faith and hope are major factors in sustaining soldiers through periods of great trauma.

Doctrine suggests prepositioning UMTs at casualty treatment locations at the last practical moment before the battle phase begins. Doing so would limit religious support to noncasualties on the battlefield during this phase.

UMTs would also have difficulty determining when to move to these points. Whereas religious support to casualties is integral to providing religious support on the battlefield, it may not be a priority in some situations. The priority for religious support may be soldiers fighting the battle who are noncasualties.

Brigade, division, and corps staff chaplains are responsible for casualties evacuated to the rear. The brigade chaplain ensures that continuous coverage is provided to all casualty care points and facilities with the brigade area of operations.

The brigade chaplain may coordinate area coverage in the task force area of operations or in areas of nuclear, biological, or chemical contamination. The brigade chaplain also provides coverage support to task force ministry teams.

In the event of mass casualties, the task force chaplain analyzes the situation and decides whether to move to the casualty site or to the casualty collection point.

The division chaplain monitors casualty data reported to the division level and ensures that the appropriate brigade and battalion level UMTs are aware of the implications of this data for effective ministry to soldiers and their families.

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SUBSTANTIVE APPENDIX F

ORGANIZATION SUMMARY

Health Service Support, AirLand Battle, according to emerging HSSALB doctrine, is provided at NATO Echelons I and II by medical support modules. The basic modules are: combat medic, treatment squad, ambulance squad, area support squad, patient holding squad, and surgical detachment.

Combat medics are assigned as follows:

Infantry	- 1 per platoon
Mechanized Infantry	- 1 per platoon + 1 per company
Armor	- 1 per company

Treatment squads have 1 primary care physician, 1 physician assistant, 2 emergency treatment non-commissioned officers, and 4 medical specialists. They may be deployed as 2 teams. They are assigned 2 per brigade and are part of a division level medical company.

Ambulance squads have 1 evacuation non-commissioned officer and 4 ambulance/aide/drivers. They are assigned 4 per brigade as part of an ambulance platoon, which has 1 platoon leader and 1 platoon sergeant, and is part of a division level medical company.

Area support squads have 1 dental officer, 1 dental hygienist, 1 medical laboratory specialist, and 1 x-ray specialist. They are assigned 1 per brigade as part of a division level medical company.

Patient holding squads have 1 wardmaster, 1 practical nurse, and 2 medical specialists. They are assigned 1 per brigade as part of a division level medical company.

Surgical detachments have 1 general surgeon, 1 orthopedic surgeon, 2 nurse anesthetists, 1 intensive care nurse, 2 operating room technicians, and 2 medical specialists. They are assigned to corps hospitals, but may be deployed as far forward as brigade clearing stations when casualties needing emergency surgery cannot be evacuated to a corps hospital within 4-6 hours.

NATO Echelon Level II health service support is provided by medical companies, air ambulance companies, and surgical detachments.

Medical companies have 3 treatment squads, an area support squad, a patient holding squad, and an ambulance platoon. The ambulance platoon has four ambulance squads. It may also have a patient decontamination section. Medical companies are assigned 4 per division, except for the air assault division which has 5.

Air ambulance companies have 15 or 25 air ambulances depending on the type of helicopter, and supporting personnel. They are assigned 2 per division.

Surgical detachments are assigned to corps hospitals, but may be deployed to division clearing stations to provide emergency surgery when further evacuation of casualties without surgery would jeopardize life or limb. Their basis of allocation is 2.6 per division.

Augmenting Echelon II medical treatment and evacuation in the combat zone are the following units, including their basis of allocation:

Medical Brigade	1 per corps HQ
Medical Group	1 per 5 subordinate Bn
Evacuation Battalion	1 per 5 Ambulance Co
Medical Detachment (Pat Decon)	1 per supported Bde
Ambulance Companies	1 per division plus 1 per three Sep Bde
Area Support Medical Battalion	1 per 70,000 soldiers
Combat Stress Control Company	1 per every 2 Div
Dental Company (Light)	1 per 10,000 soldiers

Mental health resources supporting divisions include headquarters and support companies, division mental health sections, clearing platoons, and support company clearing platoons. Each are assigned 1 per division.

Headquarters and support companies have 1 psychiatrist, 1 social worker, 1 psychologist, and 3 behavior science specialists.

Division mental health sections have 1 psychiatrist, 1 psychologist, 1 social worker, 1 occupational therapist, and 6 behavior science specialists. This section may be augmented by a psychiatric nurse, field medical assistant, occupational therapy specialist, and/or a psychiatric specialist.

Clearing platoons have 1 behavior science specialist. Support company clearing platoons have 2 behavior science specialists.

NATO Echelon III organization is yet undetermined, although it is projected to include surgical (MASH) type hospitals and Combat Support (CSH) type hospitals which will accept all classes of patients.

NATO Echelon IV medical care and treatment is provided by General Hospitals and projected Combat Support Hospitals to be located in the COMMZ. The basis of allocation for General Hospitals is 1.6 per division supported.

TAA 93 projects requirements for 33 General Hospitals to support a 20 division NATO force. The rule of thumb range is 1.6-3.0 General Hospitals per division. Best is 2 General Hospitals per division. The basis of allocation of Combat Support Hospitals in the COMMZ is yet undetermined.

NATO Echelons III and IV are also supported by Combat Stress Control Medical Companies, which are projected as being assigned one per two divisions

supported in the corps. This usually translates to one Combat Stress Control company per Medical Group headquarters in the corps.

The HSSALB Medical Company, Combat Stress Control, is composed of a 13 person headquarters and two 40 person Combat Stress Control platoons. A 12 person Medical Detachment will support each separate maneuver brigade/regiment and will be attached to the nearest Medical Company, Combat Stress Control.

Squads/teams are sent to assist in mass casualty triage and emergency battle fatigue and neuropsychiatric care. Combat Stress Control personnel supplement the preventive, consultation, education, and diagnostic functions of the mental health personnel who are organic to the units which the Combat Stress Control platoons support.

The Medical Company, Combat Stress Control, is assigned to the Medical Group or the Medical Brigade. The company headquarters collocates with the Medical Group Headquarters or the headquarters of the Area Support Medical Battalion.

Each Combat Stress Control platoon is composed of a headquarters and two sections. One section functions in the division and brigade support areas (the "Forward Section"); the other functions in the forward to mid-corps area (the "Combat Reconditioning Section").

Both sections contain five mental health professional disciplines (psychiatry, clinical psychology, social work, psychiatric nursing, and occupational therapy) and enlisted support (behavioral science specialists, psychiatry specialists, and occupational therapy specialists). The Combat Stress Control platoon also has a chaplain.

The "Forward Section" consists of four 4-person squads, each with a psychiatrist, mental health officer, and two enlisted soldiers, which may deploy as needed as far forward as battalion level aid stations. This squad may have either a clinical psychologist or a social work officer.

The "Forward Section" also has one 8-person squad with psychiatric nursing, occupational therapy, psychology, and social work personnel which can be attached to the division level medical treatment company to conduct the division's restoration program. This squad has two more psychiatric NCOs instead of two behavioral science specialists when it is a Reconditioning squad.

The "Combat Reconditioning Section" consists of one 4-person squad with a psychiatrist and a psychologist and one 8-person squad with psychiatric nursing, occupational therapy, psychology, and social work personnel. The platoon headquarters usually collocates with this section.

Other medical units supporting a NATO theater are:

Veterinary Service Companies
Veterinary Service Platoons
Veterinary Medical Platoons

Veterinary Service Teams
Dental Battalions
Dental Companies (Heavy)
Dental Teams
Medical Teams
  Maxillo-facial
  Neuropsychiatric
  Thoracic
Laboratories
Logistics Battalions (Forward)
Logistics Battalions (Rear)
Theater Medical Management Center
Medsom Support Team
Preventive Medicine (Sanitation)
Preventive Medicine (Entomology)
Division Medical Battalions
Medical Command

UNIT MINISTRY TEAM ORGANIZATION

Unit Ministry Teams (UMTs) organic to maneuver units provide NATO Echelon I religious support to casualties. Battalion UMTs provide coverage from the FLOT through battalion aid stations. Brigade and task force UMTs provide coverage for brigade clearing stations, holding areas, and other casualty collection points in the brigade area of operations.

NATO Echelon II religious support to casualties is provided by division UMTs and other UMTs, such as COSCOM UMTs, who are positioned during the AirLand Battle in division rear areas.

NATO Echelon III is the first level at which religious support to casualties is provided by UMTs organic to medical units.

Current Table of Organization and Equipment (TOE) requirements for chaplains and chaplain assistants by Structure Requirement Codes (Modified TOE Chaplain MOS Extract, dated 15 January 1986) according to current structure are:

SRC/TOE	Unit Description	ALO 1	AC	AR	NG
08111H	HHC, MEDCOM	1-06, 1-05 1-E8, 1-E4 1-E3	2		
08112H	HHC, Med Bde, Corps	1-05, 1-E6	1	3	3
08123H	Combat Support Hospital	2-03 1-E4, 1-E3	8	11	4
08123J	Combat Support Hospital	2-03 1-E4, 1-E3			

08128H	Medical Clearing Co	1-03, 1-E4	7	14	15
08223H	Station Hosp, 300 Bed	1-04, 1-03 1-E4, 1-E3			
08233H	Station Hosp, 500 Bed	1-05, 1-04 1-03, 1-E5 1-E4, 1-E3	2	14	
08303H	General Hosp, 1000 Bed	1-06, 1-05 1-04, 1-E5 1-E4. 1-E3	7	28	
08502H	HHD, Hospital Center	1-06, 1-E8	1	4	
08510H	Field Hospital	3-03, 1-E5 1-E4, 1-E3	5	12	
08581H	Evacuation Hospital	1-05, 1-04 1-E4, 1-E3	9	14	9
08581J	Evacuation Hospital	1-05, 1-04 1-04, 1-03			
08590H	Convalescent Center	1-05, 2-04 1-E5, 1-E4 1-E3		1	

This list does not reflect the exact number of personnel actually assigned due to MACOM changes in the MTOE. This is a list only of the number of units assigned to the specific SRC according to the current organizational structure.

In the Draft Table of Organization and Equipment, 08723L000, Evacuation Hospital, the UMT requirement is reduced to 1 chaplain and 1 chaplain assistant. The requirement for an additional chaplain and chaplain assistant is recognized as a deviation from MARC-driven and O & O concept spaces. Similarly, a reduction in requirements to 1 chaplain and 1 chaplain assistant is proposed in the Draft TOE, General Hospital.

The current requirements are the minimum essential required to provide religious support to casualties. Any reduction would seriously limit soldiers' rights to the free exercise of religion at times when religious support is essential to their healing and wellness.

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SUBSTANTIVE APPENDIX G

DISCUSSION AND ANALYSIS

CASUALTY DEFINITION

Casualties are any persons who are lost to their organizations by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing in action, beleaguered, besieged, or detained.

Casualties who are of particular interest to this study are those who are dead, wounded, injured, diseased, beleaguered, or retained. These casualties receive care and treatment from the Health Service Support, AirLand Battle system.

UNIT MINISTRY TEAM FUNCTIONS

The mission of the Unit Ministry Team (UMT) is to provide religious support to soldiers. UMTs provide religious support to casualties on the AirLand battlefield through providing pastoral care and counseling which promotes healing, stabilization, stress reduction, religious life, morale, and the total well-being of soldiers. Religious support is spiritual, as it is grounded in religious faith, hope, and love.

CATEGORIES OF CASUALTIES

UMT functions vary as the number and mix of casualties vary. Conventional warfare produces a different number and mix of casualties than does nuclear, biological, and chemical warfare.

The number of battle fatigue casualties varies as the intensity and the duration of the battle varies. The number of deaths, traumatic amputations, burns, and neurological injuries varies as the enemy's use of lethal weapons varies. The number and mix of diseases and non-battle injuries varies as the terrain, weather, and local environments vary.

The categories of casualties who require the most religious support are those who are:

- Dying, triaged as expectant
- Diagnosed as having life threatening conditions
- Suffering high levels of pain
- Suffering significant losses
- Suffering battle fatigue
- In moral or ethical dilemmas
- Psychically numb
- Returning to duty following treatment

UMTs organic to maneuver units provide most of the ministry to the dying. Whereas computer simulation models project that as many as 17% of all casualties may die, projections are that most of these will die before admission to Health Service Support, AirLand Battle hospitals.

NATO Echelon III health care support is sufficient to provide a motality rate no greater than 1% and a morbidity rate of no greater than 5% of all casualties admitted to Echelon III medical treatment facilities.

The Combat Zone Assessment (CZAR) model projects 55 different patient classifications which are life threatening. According to TAA 93, approximately 16.6% of the casualties admitted to Echelon III hospitals are so classified.

These patient conditions include: cerebral contusions, head and neck wounds, high percentage burns, abdominal wounds, traumatic amputations, and various multiple fragment wounds involving the brain, chest, abdomen, and limbs.

The number of patients who will suffer high levels of pain is impossible to estimate. The quickness and availability of medical treatment and pain reducing medications help reduce the pain that casualties experience. However, it is expected that significant numbers of casualties will experience high levels of pain.

Burn patients in particular frequently experience severe pain. Approximately 3.9% of those admitted to Echelon III medical facilities in a conventional warfare scenario may have burn injuries. Nuclear warfare would produce an even greater number of burn injuries.

Highly lethal battlefields produce many significant losses and sacrifices. They include the loss of: buddies, limbs, physical capabilities, faith, hope, illusions, and other things of sustaining symbolic value.

As losses are grieved in many varying ways, UMTs provide casualties assistance in contextualizing their losses either theologically or philosophically in such a way that grief does not become disabling or limiting. The number and impact of these losses and sacrifices is impossible to estimate.

TAA 93 projects that approximately 6.6% of the casualties admitted to Echelon III and IV hospitals may suffer the loss of one or more limbs. Approximately, 24.8% may suffer serious multiple fragment wounds.

Approximately, 39.1% of the casualties admitted may suffer injuries requiring more than 90 days of medical hospitalization. Approximately, 8.4% may suffer disabling injuries requiring military discharge after treatment in Echelon V medical facilities.

UMTs provide spiritual and other resources essential to resolving grief associated with these losses and sacrifices.

As many as 1 out of 3 casualties may be a battle fatigue casualty. This depends upon the intensity and the duration of the battle. TAA 93 projects

that approximately 2.9% of casualties admitted to Echelon III hospitals may be stress casualties. Another approximately 6.7% of admitted casualties may be neuropsychiatric casualties.

Most battle fatigue casualties will not be admitted to Echelon III or IV hospitals, but will be treated by far forward mental health and combat stress control units. They receive treatment as the tactical situation permits at reconstitution and reconditioning collection points.

UMTs organic to maneuver units and the chaplain currently proposed as a member of the Combat Stress Control Platoon will provide religious support to these casualties.

Moral and ethical dilemmas do not produce medical casualties in the strictest sense. However, they can be just as immobilizing. When soldiers question the purposes and values for which they are risking themselves, they are less effective. When leaders later question decisions which they interpret as contributing to losses and sacrifices, they may lose the initiative required to pursue the battle.

UMTs encourage moral and ethical behavior congruent with personal and cultural identity, normative value systems, and frameworks of meaning that are both responsible and responsive to the exigencies of battle. They provide religious support to those in grief and to those experiencing guilt because of past actions. They offer religious insights and spiritual resources to aid resolution.

Psychically numb soldiers also are not medical casualties in the strictest sense. These are soldiers who because of experiencing the shock and trauma of the modern battlefield have become emotionally anesthetized, ethically immunized, and/or no longer horrified.

Social isolation, sociopathic behavior, breakdowns of symbolic connectedness with their environments, disillusionment, cynicism, and permission for collective destructiveness often result. Normal bereavement may be suppressed. These casualties often look hollow eyed and distant. Their desensitization limits their capabilities to work together with others. Their behavior may be destructive of group goals.

UMTs provide religious support to the pschically numb through encouraging sensitivity to others and providing assistance in resolving the grief and guilt to which psychic numbing is the coping response.

Casualties who after treatment can return to duty within the theater evacuation policy have few illusions about the risks and sacrifices of battle. They may be more anxious about going into combat than soldiers new to combat. They may also be more battle wise about how to survive and win the battle. Their unit may have been reconstituted. Their buddies may have been killed or become casualties. They both know and do not know what to expect upon their return.

UMTs address returning to duty soldiers' anxiety and fear. They provide spiritual reassurance and other spiritual resources. They encourage belief systems, world views, and frameworks of value and meaning that will be supportive to soldiers in combat. They assist soldiers in developing sustaining attitudes, religious faith, and hope. They stress the importance of the spiritual.

SPIRITUAL CONDITIONS

This study has identified five separate but interrelated spiritual conditions to which Unit Ministry Teams respond. They are: crisis of faith, fear, grief, guilt, and despair. Casualties may suffer one or more of these conditions. Each of these conditions can be disabling or limiting.

These conditions are spiritual when soldiers relate them to ultimate meanings, values, and realities; when they relate them to faith relationships with God and communities of faith; when they make them the subject of theological inquiry; when they conceptualize them theologically using "God" language; and/or when they resolve them using religious resources.

Crises of faith are losses in confidence in centers of meaning and value. These may include losses of confidence in military values and purposes, leadership, the medical system, friends, family, self, life's purpose and value, and ultimately God.

Casualties may question why a loving, just, and omnipotent God permits the suffering and sacrifices of war. They may experience the centuries old theodicy dilemma first articulated by the philosopher, Epicurus, and later further articulated by the philosopher, Leibnitz.

If God is, and if God is both able and willing to alleviate suffering, why doesn't God do it now? If God is able, but unwilling, God is both uncaring and unjust. If God is unable, but willing, God is impotent. If God is both unable and unwilling to alleviate suffering, God is existentially removed from the plight of those who are suffering. Each option offends traditional beliefs about who God is, hence the dilemma.

The faith of those suffering this dilemma affects how they resolve it. Some believe that it cannot be resolved now, but someday will be, as suffering ends or lessens. Some believe that suffering can be alleviated by human means, perhaps divinely inspired.

Others believe that suffering is God's will and/or plan and place much of the responsibility for suffering upon God. This option often results in suffering people being angry at or blaming God, or losing their faith in God's existence.

One biblical perspective is that redemption comes through suffering (Romans 8:17; Philippians 3:10; I Peter 4:13 and 5:10). Other religious people, citing the Book of Revelation, interpret suffering as reflective of an ultimate apocalyptic conflict between the forces of good and evil, God and the

personified powers of evil. Another biblical perspective is that redemption is coming for those who wait (Romans 8:18; Philippians 1:21; I Peter 5:10).

Public opinion polls claim that a majority of Americans believe in heaven and eternal life as the final resolution. In any case, physical death is the final resolution and the time when suffering ultimately will end.

Casualties may question traditional religious teachings. They may challenge them as meaningless platitudes and oversimplifications. They may question their helpfulness. They may question the truth of the teachings of charasmatic religious authorities.

Casualties may question the possibility of their own salvation and religious images of eternal life. They may perceive death as movement toward meaningless nonbeing. They may withdraw into cynicism, paradox, and despair. All such responses when not resolved are disabling and limiting. They affect the will.

Unit Ministry Teams assist casualties to regain confidence lost in God and other centers of meaning and value through listening, sharing reflections, praying together, and vicariously sharing the suffering.

Reassurance that God is indeed caring, just, and powerful to act, at times even miraculously, calms and sustains those who are suffering. Reassurance that supporting systems are compassionate, just, and responsive to human needs assists casualties to regain confidence in leadership and medical care. Reassurance that friends and families deeply care helps improve morale and encourages hope.

UMTs assist those to whom they provide religious support to affirm and develop belief systems, world views, values, and meanings that are supportive to healing and stabilization when they are wounded, injured, or diseased. These coping resources assist soldiers to face the future with faith and hope.

The second spiritual condition is fear. Fears of suffering, pain, abandonment, the unknown, and losses of life, limb, physical potentials, and things of treasured symbolic value are common to humanity and not uniquely spiritual.

Fear is a spiritual condition as it is related to ultimate realities. Some of the best coping responses are religious.

Psalm 23, "though I walk through the valley of the shadow of death, I will fear no evil," has assisted Christians and Jews to cope with fear for centuries.

Jesus' saying, "...do not fear those who can kill the body but cannot kill the soul" (Matthew 10:28), has been similarly supportive. Likewise the statement, "Therefore do not be anxious about tomorrow, for tomorrow will be anxious for itself. Let the day's own trouble be sufficient for the day" (Matthew 6:34), has calmed many anxious persons.

Faith in God, God's loving presence, God's power to intervene, God's protection, and God's involvement in producing positive outcomes are common to all religions. Those experiencing fear in particular have traditionally embraced these beliefs as sustaining.

UMTs assist casualties to affirm and develop faith as "the assurance of things hoped for, the conviction of things not seen" (Hebrews 11:1). They remind casualties of traditional spiritual resources. They pray with and for those in fear. They share the terrors of the battlefield. They demonstrate by their presence a faith and composure that is sustaining when in fear.

The third spiritual condition is grief. Grief is experienced after significant losses. These include: the death of others, losses of limbs and capabilities, marital separations and divorces, losses of other relationships, or losses of items of symbolic value and meaning. Soldiers may grieve even seemingly insignificant losses, such as good luck charms or small possessions, depending upon how significant they were to them.

Responses to grief are many and varied. Denial, sorrow, catharsis, anger, withdrawal, depression, and adjustment are among the many possible. Some are more disabling or limiting than others. Some responses are considered culturally, medically, and spiritually as more healthy or mature than others.

Denial is not usually viewed as healthy. Trivializing is not usually viewed as mature. Some responses are more supportive of leaders' goals and objectives, so may be preferred by leadership. Giving up or disabling depression are not supportive. Redirecting energies may be. Acceptance and adjustment are supportive.

Grief may also be anticipatory. Soldiers may dwell upon potential losses, both significant and seemingly insignificant.

Treated casualties who are returning to duty know the risks of losses and sacrifices of the modern battlefield. They may be convinced that they will die this time as they return to duty. Casualties who have suffered losses of limbs, capabilities, attractiveness, or potential may anticipate further losses upon their return home or to civilian life. They may fear rejection.

UMTs assist soldiers and casualties suffering grief through facilitating catharsis. They assist soldiers to tell their story until it is purged of its horror. They encourage them to include their experience in a framework of value and meaning which assists integration and acceptance.

UMTs assist casualties to reframe their experiences within contexts of faith and hope. UMTs provide assurance of God's love, salvation, and eternal life for those grieving the deaths of others. UMTs assist casualties in evaluating the meaning of their losses.

UMTs also provide reality testing for those anticipating losses. They may assist soldiers to come to terms with the possibility of their own deaths. They pray with and for soldiers. UMTs faciltate the grief process. They contribute to returning well adjusted soldiers to duty or civilian life.

The fourth spiritual condition is guilt. Persons who have made real or perceived mistakes and who deeply regret them often experience guilt. Religious persons frequently label these mistakes as sins. They ascribe to them an ultimacy that is spiritual.

Casualties as survivors may question why they lived and others died on the battlefield. They may feel guilty that other persons judged by them to be better persons died and they did not. They may have regrets about mistakes they made that contributed to others' deaths.

Or they may regret actions that they did not take or decisions that they did not make that would have saved lives. Some medical treatment personnel later regret triage choices that mass casualty situations required them to make.

Some soldiers, including many leaders, have grandiose senses of responsibility for others. They believe that they can protect others from harm. When others are killed or wounded, these leaders often feel guilty.

Some survivors regret leaving the battlefield as casualties. They regret leaving their buddies behind to fight without them. This survivor guilt can be disabling or limiting.

Some casualties have participated in immoral behavior about which they later feel guilty. This behavior is often incongruent with their life-style or values. They may have committed, not opposed, or sanctioned atrocities. They may have engaged in sexual immorality. They may fear that they have committed mortal sins that will affect their possibilities of salvation.

Guilt is often related to low self-esteem, feelings of inadequacy, or poor self-images. It may be related to an inaccurate appraisal of a situation or an aspect of personality.

Dying casualties may interpret their condition as punishment for sins. They may question their worthiness before God. They may regret actions which they interpret as hastening their deaths. Many dying persons express a need to make their peace with God.

Guilty persons may even adopt a death desiring attitude that can be self-destructive or lead to a loss of the will to live when they become casualties. They may give up or give in too easily.

UMTs provide religious support to the guilty through providing opportunities for confession, repentence, and absolution. They proclaim forgiveness, i.e. acceptability in relationship to God and religious community. Roman Catholic priests and others may also prescribe penance. Others recommend restitution in so far as it is possible.

Most rites for the dying include opportunities for confession and absolution. Jewish theology prescribes the deathbed confessional as an important element in the transition to "the world to come" (Yoreh Deah 378).

That Jesus Christ died for the sins of all is a primary belief of the Christian religion. The Christian sacraments of Baptism and Holy Communion proclaim forgiveness of sin. As representatives of God and religious communities, chaplains often assist soldiers to restore relationships with God and others. They provide spiritual resources that others caring for casualties cannot provide.

The fifth spiritual condition is despair. Casualties experiencing despair have lost all hope. They may feel that everything of value and meaning in their lives has been defeated. They may be disappointed at what life offerred them. Everything may seem to them to be futile. They question the meaning and purpose of their losses and sacrifices. They wonder if anything is worth fighting and dying for. They may feel victimized, scapegoated, or dehumanized. They may be disillusioned and cynical.

Despair often occurs when psychic numbing and desensitivity are no longer effective coping mechanisms. Persons in despair hurt deeply. They can see no hope beyond. They see absolutely no end to or resolution of the suffering.

Those in despair may be suicidal, engage in self-destructive behavior, or be extremely angry. Although some may withdraw into quiet dying, others may become extremely combative. They may not care enough to join with others in accomplishing group goals and objectives. They may be not fully participating as members of a unit. Despair can be extremely disabling and limiting. It embraces every aspect of life.

UMTs provide religious support to those in despair primarily through being available as a supportive and caring presence. UMTs listen when those in despair talk. They provide religious and spiritual resources when those in despair are receptive.

UMTs assist those in despair to recontextualize, reframe, or relabel their experiences theologically and philosophically, so that experiences have more value and meaning. Overcoming despair may be a slow process. The UMT's faithfulness and continuing concern can be instrumental in resolving the crisis.

BATTLEFIELD RELIGIOUS SUPPORT TO CASUALTIES

This study has identified eight different but interrelated types of religious support that Unit Ministry Teams provide to casualties. They are:

Ministry of Presence
Ministry to the Dying
Ministry of Sustaining
Sacramental Ministry
Crisis and Stress Ministry
Ministry of Guiding
Ministry of Worship
Ministry of Celebration

Each of these ministries is essential to healing, stabilization, and maintaining spiritual wellness. UMTs may provide one or more of these ministries to any one casualty. Soldiers in crisis who profess no religious preferences or leanings may also benefit from them.

Ministry of Presence

In accordance with Forward Thrust doctrine, Unit Ministry Teams (UMTs) will be far forward in combat with soldiers. They will experience most of the same risks and sacrifices. Although they may not be at the point of wounding, UMTs will seek out casualties to provide them religious support.

As proclaimed representatives of God and religious communities, chaplains are symbols. They symbolize to soldiers whatever soldiers based upon their tradition and experience may project upon them.

Chaplains' being present for some symbolizes God's loving presence on the battlefield and God's identification with suffering. For others chaplains are symbols for transcending realities, meanings, and spiritual values. Chaplains may symbolize strength, composure, comfort, and peace which passes all understanding.

Soldiers may view chaplains as sources of wisdom and insight and teachers because of their knowledge of religious teachings and sacred writings. Chaplains may symbolize in their presence a commitment and willingness to sacrifice and give of themselves in the cause of peace. Chaplains may symbolize solidarity with God, others, and communities of faith. Soldiers may see chaplains as ones who through prayer can elicit powerful divine forces to alleviate suffering.

Some religious traditions teach that priests and saints can intervene for others before God. Others teach that priests have the divinely given authority to forgive sins.

Chaplains may be symbols of faith, hope, and love in the presence of the denial, hopelessness, and death of the battlefield. They may symbolize better futures, new beginnings, and integration. They may symbolize spiritual devotion and focus. They may be a symbol for the humane. They may symbolize a believing acceptance of suffering.

Chaplains in their presence may also be negative symbols, depending upon soldiers' past experiences. Soldiers may perceive chaplains as blessing the killing, the immorality, and atrocities of war. Some chaplains may have tacitly participated.

Some soldiers may perceive chaplains as promoting "false witness." Figley reports how one chaplain in Vietnam in a combined funeral ceremony-pep talk urged participants to "kill more of them" (Figley, p. 219).

Soldiers may perceive what chaplains say to be "b---s---,' or as rationalizing or justifying combat experiences with the ultimate authority of the spirit. They may view chaplains as noncombatants to be liabilities in intense combat environments. Some may project judgmental attributes upon chaplains.

Symbols are powerful to influence attitudes, feelings, and behavior. The chaplain's presence can buoy spirits or depress them. As chaplains provide other ministries, they can hopefully ameliorate negative symbols and support positive symbols.

Religious Needs Assessment

A religious needs assessment precedes other ministries and is a relatively quick rather than thorough spiritual diagnosis of the casualty's spiritual conditions, spiritual needs, religious experiences, and religious resources. UMTs accomplish this assessment more by compassionate listening than by questioning or taking a verbal inventory.

UMTs attend first to the casualty's physical and/or psychological conditions, as they impact upon requirements for ministry. First, is the casualty dying, in extreme pain, traumatized, or under extreme stress? What is the casualty's mental status? Is the casualty alert or confused? Has the casualty suffered a significant loss? Is there any pathology or delusions in the casualty's world-view?

Second, is the casualty experiencing a spiritual condition: crisis of faith, fear, grief, guilt or despair?

Third, what are the casualty's spiritual needs? Is there a need for prayer, anointing, confession, absolution, the sacraments, or other distinctive faith group or denominational ministrations? What is the casualty's religious affiliation?

Fourth, what is the depth and quality of the casualty's religious concerns? Are they superficial, compulsive/obsessional, profound/authentic, hostile/alienated, or sociopathic/manipulative?

Fifth, what are the casualty's religous resources, influences, or sources of spiritual comfort and/or support? What is the casualty's knowledge of supportive sacred writings? Is there a need for religious literature and/or symbols?

Sixth, what is the casualty's need for invitation to religious services, for followup visits, and referral to other helping professionals? What is the priority of need for followup?

Seventh, what are the overall pastoral impressions and recommendations?

Trained chaplain assistants and volunteers can also accomplish this religious needs assessment. They can support chaplains to determine requirements for religious support and future ministries.

Ministry to the Dying

UMTs provide religious support to the dying for those casualties whose death in imminent and/or probable. These casualties' conditions may be acute or chronic. Their death may be uncertain, but there is a known time such as after surgery that probabilities may be better known.

UMTs also provide ministry to the dying to those who perceive death as a real possibility, have premonitions, are unsure about surviving combat, or soon to risk their lives opposing an unidentified threat.

This ministry assists soldiers who are preparing for death, who are in the processes of ordering their last affairs, preparing to meet their God or maker, and making peace with God and others. These soldiers may have needs to confess, say goodbyes, give others blessings, and/or make their last contributions to loved ones.

Spiritual needs among the dying differ as individual beliefs and stages of faith differ. Immature childlike faith, which is filled with fantasy, often contains images of death that are filled with terror, punishment, and destruction.

Faith based upon a system of reciprocal fairness expects in death rewards for good behavior and punishment for bad. These casualties may question what they have done to deserve death, the fairness of death, and the why of death. They may attempt to bargain with God.

Conventional, non-analytical, and strongly interpersonal faith may embrace death as God's will or a person's lot in life. These casualties believe what the majority do. They often accept non-analytically what they have been taught by charismatic religious authorities.

Faith, when it is a function of personal identity shaped by experiences, struggles, critical reflection upon values and meanings, and interest in self-actualization, may perceive death as a disruption in life with all its many possibilities for self-fulfillment. These casualties may deeply reflect upon death's meaning. They may perceive death as a state of nonbeing that is impossible to conceptualize. Death is therefore a highly individualistic experience.

When faith is a way of seeing, knowing, and commiting which recognizes the complexity of life and its meanings, the interrelatedness of everything, and the partiality of truth, death may be approached with wonder. These casualties believe that there are no simple answers to death's meaning. So they accept death within a framework of partial meanings, paradoxical understandings of truth, and within a context of irrevocable commitments and acts.

For a few, faith is a comprehensive vision of truth which transcends parochial perceptions of justice, embraces universal community, is not concerned with relevancy, and which seeks to transform present realities in the direction of transcendent realities. The life style of these casualties may have been characterized by universal compassion. Death for them is not all that important, so they may be willing to take extraordinary risks in service of others. They may choose to die for the sake of some universal principle, God, or others. This choice often is not understandable to others.

Each of these stages of faith and their related perspectives on death require a different pastoral approach. The goal in all cases is to affirm the individual in a faith and perspective that assist them to accept the reality of their death and which eases the transition from life into death. Most religious traditions affirm life after death as a real possibility. This belief helps sustain dying persons as few other beliefs can.

Death perspectives for religious persons are related to their images of God. If soldiers perceive God to be compassionate, saving, powerful, near, caring enough to intervene in present or future life, they usually perceive God as aiding the transition through death. If they perceive God to be vengeful, judgmental, impotent, remote, unwilling or unable to intervene in the present or future state of being, they usually perceive God as not helpful at the time of death. They may perceive God as a friend or as someone to be feared.

Death perspectives are also related to past experiences of faith. Some have experienced God intervening in previous crises. Some have experienced the meaningfulness of religious teachings in previous confrontations with death, serious illness, or injuries. Some have experienced the helpfulness of prayer. Some have learned helpful ways to contextualize or frame their experiences theologically. Some have experienced a solidarity with a community of faith that has helped them in past crises.

Remembering these experiences can aid transitions through death. Those who have had these experiences look often to Unit Ministry Teams for religious support similar to that which they experienced in the past.

Ministry to the dying attends to the spiritual conditions previously discussed. Dying soldiers may experience crises of faith, fear, grief, guilt, and despair.

The dying may lose confidence in God and others. They may question why a good God lets them die. They may reevaluate their beliefs. They may question religious teachings about heaven, hell, and eternal life. They may question the possibility of their own salvation. They may perceive death as movement toward meaningless nonbeing.

UMTs assist dying casualties to embrace belief systems, world views, values, and meanings which aid the dying to accept death within the context of life. This helps ease the transition.

The dying fear the unknown. They fear what will happen to their bodies, families, plans, and projects. They wonder how their families and friends will respond emotionally. They wonder about their fate in the hereafter.

Some fear loneliness and abandonment in dying. They fear the sorrow of dying. They wonder if dying will be an overwhelming emotional experience.

Some fear loss of identity, integrity, image, adequacy, and dignity. They fear losing control of bodily functions, strength, rationality, courage, self-determination, composure, the ability to communicate, and consciousness. They wonder if they will be able to take the pain of dying, whether pain medications will be sufficient.

The dying often anticipate their losses and grieve. They grieve for their families as well as for themselves.

The dying may deny their dying. They may become angry at death's unfairness. They may bargain with God to get well. They may become depressed. They may look for magical cures or second opinions. They may have psychotic breaks with reality.

UMTs assist the dying through facilitating catharsis and assisting the dying to face the meaning of each potential loss. UMTs provide assurance that families will receive help and ministry. UMTs assist the dying to accept death within the context of life. They affirm spiritual resources as being among the most supportive.

The dying may feel guilty and interpret death as punishment for sin. UMTs assist the dying to contextualize theologically what they regret. They provide opportunities for confession, proclaim absolution, and assure the dying of God's forgiveness. They aid the dying to make their peace with God and others. They affirm individual worth and dignity. They provide supportive sacraments and rites.

UMTs provide religious support to the dying who are in despair through encouraging them to take leaps of faith. They encourage hope. They assure the dying through faithfulness and presence that they are not forsaken. They assure them that God indeed cares.

UMTs may suggest that death can even be transcended. Most religious traditions teach that death can be transcended and have a meaning beyond itself. Many teach that there is life beyond the grave.

UMTs assist the dying to include death within the universe of values and meanings. They affirm solidarity with God, others, and a community of faith.

The ultimate spiritual goals of ministry to the dying are spiritual wholeness, salvation, thanksgiving, and even a quiet joy in confronting death.

UMT tasks include: being there, listening compassionately, facilitating expression of feelings, thoughts, and visons of the future, and hearing the frustration and the anger. UMTs provide empathy. They answer questions to

which answers are known, such as what will happen next, and what happened to buddies.

UMTs facilitate exploration of theological issues, values, and meanings. They provide reality testing for the confused and disoriented. They provide human contact, touch, and appropriate holding. Many have reported how soldiers "died in their arms."

UMTs assist the dying to order their last affairs. They may facilitate the writing of letters to families or saying goodbyes.

UMTs support as much self-initiative, self-determination, and participation in medical treatment as is possible.

UMTs pray with and for the dying. They share sacred writings. They discuss future hopes. They communicate divine grace and promise.

Ministry of Sustaining

UMTs provide the ministry of sustaining to casualties for whom total healing or restoration to former conditions of wholeness are not possible, or at least not in the near future. They provide this ministry to casualties whose conditions will not soon or ever change very much. They provide it to those suffering from an irreversible loss or process of degeneration or impairment.

These casualties include: those who are permanently or temporarily quadriplegics or paraplegics, amputees, the disfigured, those who have significant brain or organ damage, those who must use machines to maintain life, and those with other permanent disabilities.

UMTs also provide the ministry of sustaining to those whose situational, environmental, or mental conditions will not change or at least not very much. Those in relationships with casualties who have experienced losses may also benefit from this particular ministry.

A primary goal in sustaining ministry is the transcendence of circumstance in the direction of healing and hope. Another goal is to prevent the experience of the tragedy, illness, pain, suffering, or loss from destroying the faith of the casualty in the person of God, God's saving work, God's care, and God's power to heal and sustain.

UMTs assist casualties to find the courage to confront and/or live with their disability. They encourage others who are "standing by" to affirm their contribution to this ministry.

UMTs accomplish sustaining ministry by forming a partnership with the casualty. They lend composure, courage, strength, faith, wisdom, insight, spiritual maturity, and the peace of God to the one suffering, who lends fear, anxiety, weakness, doubt, sense of powerlessness, frustration, anger, and/or

despair to the relationship. Henry Nouwen calls this entering into solidarity with others.

UMTs offer soul friendship, unconditional acceptance, compassionate listening, accurate empathy, faithfulness, loving and caring presence, mutual respect, and connectedness with a community of faith. They offer being there, being with, and being for the one suffering.

UMTs offer comfort, more often than not through silent companionship. Casualties often perceive verbal support as trite, simplistic, unrealistic, falsely reassuring, or demonstrating a lack of empathy or understanding of the gravity of the condition.

Sustaining ministry affirms the intrinsic value, innate dignity, and unalienable worth of the casualty. It attempts to elicit inner resources which can help the person sustain the self from within. It assists verbalization and expression of the sufferer's self, including needs, wants, feelings, interpretations, visions of the future, and inner resources of faith. UMTs confirm inner resources as essential.

UMT members may also share their own faith and hopes. The faiths and hopes of one can buoy another's. The UMT communicates that God cares, understands, and will help.

The UMT refuses to be discouraged when those who are suffering are discouraged. It encourages self-initiative and independence.

The UMT does not settle for merely supporting casualties, as this can easily degenerate into an unhealthy dependency. It aids the biblically referenced progression from suffering to endurance to character to hope that does not disappoint (Romans 5:3-5).

The UMT continually struggles with what it means to bear one another's burdens. It collaborates with those suffering in making the tough decisions. It remains as faithfully present as situations permit.

The paradox is that real sustaining emerges only when the direction of this ministry is toward healing, and the force of circumstance is also recognized.

If there is not direction toward healing, then hope is compensatory and illusory. If the force of circumstance is denied and hope identified only with the fact of healing, then it is bound to be frustrated and disappointed. When hope is entirely futurized, there is also an impediment toward the necessary present work of healing. When hope is seen as entirely in the present, then there is an impediment to affirming future hope.

Crisis and Stress Ministry

UMTs provide crisis and stress ministry to combat stress reaction, multiple trauma, high percentage burn, nuclear, biological, and chemical

casualties. They also provide it to those who are suicidal or who are suffering high levels of pain. Medical treatment personnel who are under great stress also benefit from this ministry.

Situations producing these casualties include major losses, such as: limbs, buddies, and family members. Experiences of the horrors and brutalization of the modern battlefield may produce revulsion and shock. Seeing badly mutilated, injured, and dead soldiers may raise stress levels so high that soldiers have difficulty functioning.

Battle fatigue casualties may experience crises of faith, disabling fear, grief, guilt, psychic numbing, and/or despair.

The primary goal of UMT religious support is prevention. UMTs promote the development and reinforcement of inner strength, stability, and other resources which will aid soldiers in coping with the chaos and horror of the battle.

Emotionally and spiritually healthy belief systems, world views, value systems, frameworks of meaning, and faith help prevent combat stress from becoming disabling and limiting.

Good nutrition, adequate rest, physical fitness, good personal hygiene, and supportive interpersonal relationships also are important.

UMTs support soldiers in their search for God and meaning on the battlefield. They affirm the importance of inner, other, and divine resources for alleviating stress. They aid soldiers in integrating their combat experiences into frameworks of meaning that facilitate acceptance. They offer opportunities for spiritual renewal and supporting sacraments. UMTs affirm the dignity and worth of all soldiers.

UMTs may teach stress reduction techniques, such as creative visualization, reframing, and prayer. They may assist soldiers in coming to terms with their own deaths in individual and group counseling. They may teach ethical decision making strategies, affirming moral behavior congruent with personal and social values, in order to reduce the incidence of guilt. They may teach communication skills supportive of trusting interpersonal relationships, unit cohesion, and morale.

UMTs encourage sensitive awareness of others and their needs. They provide religious literature and symbols. They pray with and for soldiers prior to, during, and following battle. They provide supporting sacraments, rites, and other ministrations. They lead services of worship and memorial services.

Pastoral care tasks include assisting emotional and spiritual catharsis, relabeling, reframing, and assigning meaning to experiences. UMTs provide assurance that the dead will be treated with dignity, that there's hope for the future, and forgiveness for the past.

UMTs assist soldiers to review their experiences objectively. They help debrief soldiers who have experienced the chaos and horrors of battle. They

attempt to deconfuse situations and memories and limit overdramatization. They assist closure, confront secondary gain issues, and assist integration. They confront fears, trust issues, and unhealthy interpretations. UMTs encourage and enhearten soldiers as they return to duty.

Ironically, UMT religious support may be perceived as using spiritual authority "to seal off in the men some inner alternative to the irreconciliable evil they were asked to embrace" (Figley, Stress Disorders Among Vietnam Veterans).

Ministry of Guiding

UMTs provide a ministry to guiding to those in ethical or moral dilemmas, value conflicts, and interpersonal conflicts. They address behavioral, morale, unit cohesion, organizational effectiveness, and leadership issues.

The goal of a ministry of guiding is that soldiers and their leaders have the best available knowledge and resources for effective decision making, conflict resolution, and problem solving. As this is done, normative standards and criteria develop.

UMTs affirm and teach ethical behavior congruent with personal and cultural identity, values systems, and meanings.

The three basic forms of the ministry of guiding are: inductive, eductive, and collaborative.

Inductive guiding is leading others to adopt a priori sets of values and criteria by which to make decisions. Basic norms, values, and sensibilities that govern the culture of the guiding group are implanted within the character of the ones being guided. Persons are given a structure, a character, an identity, a religiocultural value system out of which to live. They are induced into progressively higher levels of perfection. A moral universe of values and meanings is shaped.

Inductive guiding is most appropriate for persons lacking perceived healthy world views, value and belief systems, and frameworks of meaning. It is also helpful to those searching for new or renewed values or belief systems because their's are inadequate.

Inductive guiding:

- Defines alternatives
- Provides patterns, procedures, pathways, and systems of normative conduct
- Provides the guiding group's values and standards as good, true, and normative
- Suggests rational codes of daily ethical behavior and attitudes and how these might be ordered and structured

- May proclaim what the group understands as moral and ethical demands as the will of God
- Encourages responsible action, congruent not just with personal identity, goals, values, and norms, but also those of the guiding group
- Encourages others to share the identity of a culture with its symbols, stories, and norms for conduct
- Assists persons to develop relevant frameworks of meaning through reference to external insights, perspectives, and interpretations
- Helps persons become incorporated into the group, accepting group goals, values, and norms as their own
- Tells persons what they should do with their freedom
- Uses group confrontation and correction in disciplining
- Attempts to reconcile the lapsed

The limitation of inductive guiding is that some may use it to coerce, persuade, or manipulate others into accepting group goals, values, or norms. They may impose solutions in attempts to be influential. A very small, powerful, or influential subculture may use it to control others. Thus in attempts to develop, nurture, pattern, and limit others, some may use it to restrict individual freedom and deny individual rights.

Eductive guiding as the antithesis of inductive guiding draws out of individuals' own experiences and values the criteria and resources for decision making. It educes solutions, both moral and ethical. It evokes or leads out of that which are internal goals, values, and norms. It assists troubled persons to clarify and reshape emotional responses within their own value frameworks.

Eductive guiding is most appropriate for those who have healthy internalized world views, belief systems, and frameworks of value and meaning, and/or who are part of a clear moral context which has a fund of normative values and meanings.

Eductive guiding:

- Provides strong supportive relationships of acceptance, empathy, and respect
- Facilitates the exploration and sorting out of feelings, belief and value systems, and meanings
- Is non-directive, concentrating upon dynamic, motivational and emotional issues
- Stays at the level of feelings and motivations without raising issues of normative conduct
- Attempts to function within the value systems of troubled persons
- Affirms internal resources, frameworks of value and meaning, world views, belief systems, and perspectives as adequate for coping with the conflict or issue, and affirms individuals' own potentials for solving own problems
- Helps persons discover lost capacities for decision and initiative
- Affirms expressiveness, spontaneity, openness, and feeling responses

The limitation of eductive guiding is that it is unwilling to tackle the hard problems of restructuring the normative and cultural value systems by which people within groups can work better together and better accomplish group goals. It abdicates responsibility for moral inquiry and shaping a moral universe of values and meanings.

Eductive guiding can be morally neutral, antimoralistic, antiascetic, or antirationalistic in sensibilities and values. It may support simplistic and naive world views, belief systems, and frameworks of value and meaning, simply because troubled persons find them helpful.

Collaborative guiding is a synthesis of inductive and eductive guiding in that it combines the strengths of each. It affirms both internal and external resources, world views, belief systems, and frameworks of value and meaning as potentially helpful to troubled persons seeking guidance.

Collaborative guiding is a collaborative process in which the providers and recipients of this ministry journey together in a mutual search for alternatives. Individual needs, beliefs, values, meanings, and norms are balanced with those of the group. The goal of collaborative guiding is to develop a shared universe of values and meanings that is relevant to the situations being experienced.

Collaborative guiding is most appropriate for those in transition, whose previously accepted beliefs, values, meanings, and norms are no longer adequate for coping with current situations. Recipients must value both external and internal resources and perspectives and be willing to explore alternatives in a collaborative relationship in order for this form of guiding to be effective.

Collaborative guiding:

- Provides a relationship of acceptance and mutual respect
- Affirms individual potential for resolving conflicts and issues, while recognizing dependency needs and others' capacities for suggesting helpful alternatives
- Raises issues of normative conduct without imposing the values of the group
- Explores personal and cultural identities
- Encourages responsibility to selves and others
- Encourages value commitments
- Affirms individual freedoms and rights within the context of group life and group goals
- Discusses understandings of God's will
- Encourages ethical decision making as it considers as many factors as possible
- Encourages mutual edification
- Affirms rationalism and asceticism
- Supports discipline and accountability
- Encourages faithfulness to relationships

The limitation of collaborative guiding is the complexity of the process. Not all factors may be known or knowable. Dependency needs may be denied. God's will cannot be precisely known. Personal identities may be maladaptive or subcultural. Individual potentials vary. The personalities of collaborators, their varying skill levels, their differences in knowledge, and their positions of authority may balance decision making more in the direction of some than of others.

The ministry of guiding is a traditional and essential ministry of the Unit Ministry Team. UMTs have traditionally provided spiritual, moral, and ethical guidance to soldiers and their leaders. This guidance has assisted soldiers in coping with the trauma of battle and in making humane, ethical, and responsible decisions.

It is essential that as many factors as possible be considered when making decisions which risk lives. Ignoring the values and norms of the culture from which soldiers come and for which they are fighting only increases the likelihood of their being poorly supported in battle by society and their being not warmly received back into society following the war.

Ministry of Worship

UMTs provide a ministry of worship to soldiers before, after, and during lulls in the battle. They lead groups of soldiers in prayer, praise, and thanksgiving. They share readings from sacred writings, lead meditations upon them, and explore their meaning for soldiers in battle. UMTs provide religious sacraments, rites, and other formal ministrations supportive of spiritual life.

The goal of worship is to strengthen, sustain, enlighten, and inspire soldiers spiritually. Worship is an opportunity to say thank you to God for past blessings and to pray for future blessings. It is an opportunity to hear God's assurances of forgiveness and to hear the facts of God's loving presence and eternal salvation proclaimed. It is an opportunity to receive faith and grow in faith and trust in God.

The Word of God works to create and preserve faith, hope, and love. The Good News of God's activity in our world is a Word of life that frees and reconciles.

"Faith is trust. Faith is the willingness to wage life and limb on the center of value, the power of being, the Good, the Word that is the trust of life, the Holy One who determines our identity. This trust is the sustaining heartbeat of hope and the sustaining source of love." (Lutheran Partners, Jan/Feb, Andrew M. Weyermann)

The worshiper wants to trust, but cannot. The worshiper comes to receive trust in the miracle of faith. Faith overcomes the doubts. It enables risking of life and limb in the service of others. Faith provides a vision of the eternal.

Worship also proclaims forgiveness. Soldiers often feel condemned if they do fight because of what they must do to defeat the enemy and survive the battle, and condemned if they do not fight because of not in honor answering the call of their country to defend the national interest and help others maintain their freedom.

Modern warfare often forces soldiers to choose between what is bad and what is worse. In worship soldiers receive the unconditional grace of God that forgives all choices. In forgiveness they find "the freedom to do what the Spirit leads each of us to do by way of justice and mercy in a world too bent to enable us to do it cleanly."

The "task is to proclaim God's final verdict of forgiveness so that the hearer, by accepting God's grace, may be freed from the judgment cycle in spite of having to live out his or her life in the judgment cycle." Thus worship empowers soldiers for new life. It empowers them to serve to the limits of human endurance in battles which defy all sense, are basically evil, and have all the marks of judgment.

Forgiveness enables soldiers to do what they have to do without fearing eternal damnation. Faith enables them to have trust in God's ultimate victory and salvation no matter what happens to them personally on the battlefield.

Soldiers in gathering together share mutual faith, hope, and love, thus strengthening cohesion. They join together in mutual support. They join in worshiping a common center of value and meaning.

Worship is essential to sustaining soldiers in battle. It builds them up. It encourages them. It prepares them to face the trauma of battle. It assists them to develop the spiritual resources that will sustain them if they become casualties and promote their healing and stabilization. It helps prevent soldiers from becoming battle fatigue casualties. Worship is a resource provided by Unit Ministry Teams as a primary function.

UMTs may individualize the ministry of worship with casualties at the point of wounding, at a casualty collection point, or at the bedside. They may conduct it in a ward for the nonambulatory, or in a dining facility, or in a chapel for those who can walk. It may be brief. It may involve the entire unit, as do most memorial services. It may involve only a few.

Representaitves of particular religious groups may provide worship to members of a distinctive religious group. But worship is usually nondenominational and all faith on the battlefield.

The content of worship may vary considerably. It may include singing or other music as available. It may be according to a prescribed form or liturgy. But the basic ingredients remain the same: prayer, sacred readings, meditation, doxology, and assurances of God's grace and blessings.

Sacramental Ministry

Sacramental ministry is different for each religious group. Some sacraments can only be provided by a representative of an individual's own religious group. Specific materials may also be required. Some religious groups separate religious ministrations into sacraments, rites, ordinances, and other ministrations.

Soldiers may request or participate in sacraments, rites, ordinances which are not part of their own religious tradition. UMTs may also minister to those not of their own tradition. UMTs, however, may not be required to administer to any persons if doing so would be contrary to conscience or religious group practices.

Protestant sacraments, rites, ordinances, and ministrations include:

- Baptism, requiring water and special format for most
- Holy Communion, requiring bread and wine, grape juice, or water for some. This may be private.
- Confession of Faith
- Confirmation
- Affirmation of Baptism
- Confession and Absolution
- Service of Dedication or Commitment
- Service of Healing, often including Anointing with Oil and the Laying on of Hands by elders of a religious group
- Service of Blessing
- Commendation of the dying
- Prayers for the Dead and/or Living following death

Roman Catholic sacraments, rites, and ordinances for the sick and wounded include:

- Communion of the Sick: Ordinary Circumstances
  "The minister of communion represents Christ and manifests faith and charity on behalf of the whole community..." "...the reception of communion...is a sign of support and concern shown by the Christian community." The significance of communion is: "union with Christ in his his struggle with evil, his prayer for the whole world, and love for the Father, and union with the community from which they are separated."
- Anointing of the Sick
  "This sacrament gives the grace of the Holy Spirit to those who are sick: by this grace the whole person is helped and saved, sustained by trust in God, and strengthened against the temptations of the Evil One and against anxiety over death. Thus the sick person is not only able to bear suffering bravely, but also fight against it. A return to physical health may follow the reception of the sacrament if it will be beneficial to the sick person's salvation. If necessary, the sacrament also provides the sick person with the forgiveness of sins and the completion of Christian penance."

- Viaticum
  "...the completion and crown of the Christian life on this earth, signifying that the Christian follows the Lord to eternal glory and the banquet of the heavenly kingdom." All baptized Christians are "bound" to receive Viaticum when death is close.
- Commendation of the Dying
  "Through the prayers for the commendation of the dying, the Church helps to sustain this union (union with Christ received in the Viaticum) until brought to fulfillment after death." "The Christian will be helped to surmount his or her fear in the hope of heavenly life and resurrection through the power of Christ, who destroyed the power of death by his own dying."
- Prayers for the Dead
  Prayers for those already dead, affirming that "the dead are effectively helped by the prayers of the living."
- Continuous Rite of Penance, Anointing, and Viaticum
  "...with this continuous rite those who are in danger of death are prepared to face it sustained by all the spiritual means available to the Church"
- Rite for Emergencies
  Used at the point of death or when death is very close in exceptional circumstances when even the continuous rite cannot be used
- Christian Initiation for the Dying
  Baptism for anyone close to death who can hear and answer the short questions included in this rite. May be followed by the Eucharist or Confirmation as the situation permits. Usually includes anointing with chrism by priest or deacon and communion as Viaticum
- Rite for Reconciliation of Individual Penitents
  Sacrament of penance used during communion of the sick, anointing, or Viaticum (all quotes are from the Pastoral Care of the Sick)

Eastern Orthodox sacraments, rites, and ordinances for the sick and wounded include:

- Sacrament of Holy Unction (Anointing of the Sick)
  This sacrament as related in James 5:14f has a duality, the healing of the body and soul and the forgiveness of sins. The sacrament can serve as an instrument of healing. The person either returns to health or receives increased spiritual strength to prepare for death if the person does not recover. In essence , the sacrament has two faces: one turns toward healing, the other towards liberation for illness by death (Bulgakov, Ware). The rite consists of consecration of oil, prayers for the sick, and the anointing of the person
- Sacrament of Confession: Through this sacrament sins committed are forgiven and the sinner is reconciled. The sacrament acts at the same time as a cure for the healing of the soul, since the priest gives not only absolution, but spiritual advice.
- Sacrament of Communion: Since the Eucharist is the body and blood of Christ, the Eucharist is not a bare commemoration or representation, but the sacrifice itself. Yet it is not a new sacrifice nor a repetition of the sacrifice of Calvary since the Lamb was sacrificed once for all time (Ware).

- Others are: prayers for the sick, thanksgiving for recovery, prayers for the dying, absolution of a dying person, prayers for a person condemned to death, prayers after the departure of the soul from the body, the litany of the deceased, and the interment of the dead.

Jewish tradition specifically views the period of dying (Goses) and terminal illness (Shechiv Mera) as a time when loved ones should surround, comfort and encourage the patient. Jewish law provides for death with dignity and meaning by "allowing the dying person to set his house in order, bless his family, pass on any message to them he feels important, and make his peace with God."

"The deathbed confessional is viewed as an important element in their transition to the world to come. The dying person is to be instructed to recite the confessional according to the limitations of his physical and mental condition." "And one says (to the patient), 'Many have confessed and have not died and many who have not confessed have died, as a reward for your confession you will live, and whoever confesses has a portion of the world to come'." (Yoreh Deah 378)

"Each of these procedures--repentence, confession, the ordering of one's material affairs, the blessing of family, and ethical instruction--takes into account the theological, practical, and emotional needs of the dying patient. They enable the patient to express fears, find comfort and inner strength, and communicate meaningfully with those close to him."

"Spiritual pain, then, for the Jewish patient, could include any accidental thwarting of his or her reconciliation with God, any blocking of confession, or any interference with the ordering of the patient's material affairs, the blessing of the family, and the passing on of ethical imperatives as laid down in the finest of Jewish law and tradition."

All quotes are from Rabbi Zachary I. Heller, "The Jewish View of Death: Guidelines for the Dying," in Death: the Final Stage of Growth, Elizabeth Kubler Ross (ed).

Ministry of Celebration

UMTs provide the ministry of celebration to those casualties who have survived the battle and to those who celebrate that their wounds are not more serious. Some soldiers refer to wounds serious enough to require evacuation to CONUS, but not serious enough to cause permanent disabilities or lasting pain as "million dollar wounds."

Soldiers also celebrate the victory of battle, especially when it is achieved at no great cost in human lives or injuries.

Unit Ministry Teams lead celebrating soldiers in prayers of thanksgiving and praise to God for protecting them on the battlefield. They pray with soldiers for continued healing and blessings. Thus UMTs share the joys as well as the sorrows of modern combat.

PRIORITIES FOR RELIGIOUS SUPOORT TO CASUALTIES

Priorities vary depending upon the number and mix of casualties and the battlefield situation. The number of casualties may also require the Unit Ministry Team to do their own triage. They may have to make decisions about who will receive religious support first and how much time will be spent in each pastoral contact.

The UMT's priorities will at times parallel those of medical treators. At other times, the UMT's priorities will markedly differ.

For an example, UMTs will devote both time and energy to providing religious support to expectant casualties whom medical treatment teams may not have as their highest priority for treatment, although medical resources will be devoted to caring for the expectant, relieving their pain, and keeping them comfortable.

Thus in mass casualty situations, UMTs provide the compassion and sustaining presence that medical teams would like to provide, but cannot due to the medical requirements of other casualties.

Many of the energies of Unit Ministry Teams are directed toward preventing soldiers from becoming spiritual casualties as well as physical or mental casualties on the battlefield. Many military leaders have stressed the importance of spiritual fitness on the battlefield. In fact, spiritual fitness is one of the three aspects of total wellness addressed by the Army Health Fitness Program.

COMMANDERS' EXPECTATIONS

As senior military leaders have expressed their views of the importance of Army chaplains, they have described their expectations.

General Dwight D. Eisenhower in 1946 wrote:

"A good chaplain in the Army is worth more than his weight in gold...The world is experiencing as it always has after a great war, an era of doubt, confusion, and fear. We can only travel forward with the guidance of eternal truth. It is the job of chaplains and their civilian counterparts to supply that guidance today." (Circular Letter, No. 310, 1 July 1946, p. 3)

General Omar Bradley in 1949 wrote:

"The young men in our Army today must look to their chaplain as the true guide and leader on the road to success and accomplishment. For without the essential strengthening of our best moral creeds we can never hope to achieve our goal." (Army and Navy Journal, 30 July 1949, p. 1376)

General George C. Marshall spoke of the importance of religion in the Army:

"I am deeply concerned as to the type of chaplain we get into the Army, for I look upon the spiritual life of the soldier as even more important than his physical equipment...The soldier's heart, the soldier's spirit, the soldier's soul are everything. Unless the soldier's soul sustains him, he cannot be relied upon and will fail himself and his commander and his country in the end."

"It's morale--and I mean spiritual morale--which wins the victory in the ultimate, and that type of morale can only come out of the religious nature of a soldier who knows God and who had the spirit of religious fervor in his soul. I count heavily on that type of man and that kind of Army." (Jorgenson, The Service of Chaplains to Army Air Units 1917-1946, p. 277)

General Brehon Somervell, who commanded The Services of Supply under whom World War II chaplains served, wrote:

"Living and working with the troops, the chaplains furnished one of the greatest morale factors in the war. Before battle and during it, the soldier could always turn to the chaplain for strength, and courage, for the chaplains followed troops wherever they went...The wounded received help and consolation...The dead were buried in the cloak of their faiths." (The President's Committee on Religion and Welfare in the Armed Forces, The Military Chaplaincy, a report to the President, 1 October 1950, Washington: GPO 1951, p. 13)

More recently on 29 July 1985, General John W. Vessey, Jr. said:

"The spiritual health of the Armed Forces is as important as the physical health of its members or the condition of the equipment" (Field Circular 16-51, September 1986, p. 10)

General Bernard C. Rogers, when he was Chief of Staff, United States Army, noted that chaplains are prime examples of the ecumenical movement and religious cooperation without compromise.

He wrote:

"Army chaplains in the field have always been more than just representatives of their particular faith. To a soldier in need of spiritual comfort a chaplain was a chaplain whether minister, priest, or rabbi. It is common to hear soldiers of one faith praise chaplains of another faith who were there when it counted." (The Challenges of the Chaplaincy, Bernard C. Rogers, p. 55)

He wrote further that chaplains represent "the strength which comes from believing something greater than one's self." Speaking of POWs, Rogers noted that it was faith that enabled soldiers to retain their hope when all else seemed lost.

Rogers describes the chaplain's functions as building and sustaining faith, providing for human needs, caring for soldiers' welfare, and providing a moral framework for the military community. He noted that the Officer Corps of the Army was advised that they were expected to be "the conscience of the Army." "This is doubly true in the case of the Chaplain Corps," writes Rogers.

In an article entitled "What Does the Commander Expect From the Chaplain," Colonel Quay C. Snyder writes that he expects the chaplain to be a man of God, true to his faith and willing to be a walking, daily witness of his faith. He further expects the chaplain to be tolerant of others' views, have genuine concern for people, be a warm human being, visit the hospital, but above all, be "with the troops."

Commanders' expectations in terms of specific ministries include ministry of worship, ministry of guiding (already noted), ministry of sustaining (also noted in previous statements), and caring for the dying.

On 28 November 1775, the Second Article of Navy Regulations stated:

"The commanders of ships of the thirteen United Colonies, are to take care that divine services be performed twice a day on board and a sermon preached on Sunday, unless bad weather or other extraordinary accidents prevent."

President Franklin D. Roosevelt emphasized the importance of chaplains distributing Bibles when he wrote:

> The White House
> Washington
> March 6, 1941
>
> To the Members of the Army:
>
> As Commander-in-Chief I take great pleasure in commending the reading of the Bible to all who serve in the armed forces

> of the United States. Throughout the centuries men of many faiths have found in the Sacred Book words of wisdom, counsel, and inspiration. It is the fountain of strength and now as always, an aid in attaining the highest aspirations of the human soul." (Quoted in The Best and the Worst of Times, The United States Army Chaplaincy, 1920-1945, p. 170f)

In 1942 President Roosevelt proclaimed, "And we will never fail to provide for the spiritual needs of our officers and men under the chaplains of our armed services." (Ibid. p. 189)

In the TRADOC study, "Chaplain Support to the Maneuver Battalion" (ACN 44666) by the Concepts and Studies Division, U.S. Army Chaplain Center and School, completed in 1984, 163 commanders were asked to respond to a questionaire on chaplain role expectations. 124 commanders (Infantry, 65.08%; Armor, 31.36%, and Other 1.18%) responded to the survey.

These commanders responded that the five most important chaplain tasks in combat from a list of sixteen are in descending order of priority: visiting troops (84.22%), spiritual counseling (62.52%), personal counseling (61.67%), advising staff (56.16%), and priest/pastor (47.24%).

In terms of where chaplains are best located in combat, these commanders responded: battalion aid station (43.78%), where the fighting is the heaviest (28.99%), other (23.67%), in the tactical operations center or command post (2.36%), rear area (0.57%). 77.51% highly approved of chaplains being assigned to battalions.

Other data has not been collected reference commanders' expectations. However, many commanders have listed priorities for the chaplain in combat as first to minister to the dying and second to minister to the wounded at casualty collection points. In fact, most chaplains who have died in combat situations have died while providing ministry to the dying and wounded.

BATTLEFIELD COVERAGE ISSUES

Unit Ministry Teams organic to maneuver unit provide religious coverage in the combat zone. UMTs organic to combat support and combat service support units may provide some area coverage in addition to coverage for their own units.

UMTs organic to medical units will not usually be located in maneuver battalion and brigade areas of operation in the combat zone. The one exception would be during a withdrawal, when medical units may remain in place to care for casualties who cannot be moved without risking their lives.

In a high intensity conflict it is possible that both evacuation and medical treatment resources will be overwhelmed with casualties. These combat situations and other mass casualty situations will require establishing holding areas, both for casualties awaiting treatment and for those awaiting evacuation.

These holding areas will be at the point of wounding in mass casualty situations, at maneuver battalion treatment points, at ambulance transfer points, at brigade and division casualty collection locations, and at Echelon III hospitals.

Chaplain doctrine states that responsibility for ministry to casualties moved to the rear belongs to brigade, division, or corps staff chaplains.

Chaplain doctrine (FM 16-5) also states that in the event of mass casualties, the task force chaplain analyzes the situation and decides whether to move to the casualty site or to the appropriate casualty collection point.

The brigade chaplain may coordinate area coverage in the task force area of operations or in areas of nuclear, biological, or chemical contamination. The brigade chaplain provides area coverage support to task force ministry teams, situation permitting, without waiting for exhausted, even dazed subordinates to request it.

The task force chaplain or chaplain assistant handles protocol for area coverage teams. However, each area coverage team will arrange the details required to carry out its own daily activities during such emergencies. (FM 16-5, p. 55)

Ministry to casualties in holding areas often involves ministry to casualties whom medical treatment teams have triaged.

Those whom medical teams triage as "immediate," approximately 20%, will receive immediate treatment to save life or limb and will be stabilized for further evacuation. Once treated, these casualties will be categorized as "delayed" and placed in a holding area to await evacuation. Ministries of sustaining and crisis and stress ministry are appropriate for this category of patient.

Those whom medics triage initially as "delayed," approximately 20%, are those casualties who are seriously injured, but whose treatment can be delayed after receiving minimal emergency treatment without risking life or limb. They may delay treatment due to a lack of medical resources, such as required expertise, materiel, or equipment, which may not be available at the triage location.

Medics place these casualties in a holding area until they can be evacuated, although their priority for evacuation will be high. These casualties benefit most from the ministry of sustaining and crisis and stress ministry.

Those whom medics triage as "minimal," approximately 40%, are the casualties with minor injuries or non-battle injuries or diseases who after first aid or minimal medical treatment can return to duty. Medics may place them in holding areas for rest or until their units can pick them up. Crisis and stress ministry, ministry of guiding, ministry of worship, and sacramental ministry benefit these casualties.

Those whom medics triage as "expectant," approximately 20%, are those whose possibility of survival is miniscule, even if the best medical treatment were available. The medical treatment team relates to these casualties with alertness (expectancy) to changes in their conditions and provides supportive care and pain relieving medications until the time when extensive medical resources will be available to provide more intensive life saving treatment.

Medics may make a medical decision that devoting extensive medical resources to patients triaged as "expectant" would deprive other casualties with greater chances of living from required treatment. The guiding ethical principle is providing the greatest good for the greatest number.

Medics may place these casualties in holding areas. They may or may not give them high priority for evacuation. These casualties benefit most from the ministry of dying, the ministry of sustaining, and sacramental ministry.

Medical treatment teams must often make difficult triage decisions. Staff may feel overburdened and helpless. Military commanders may require that those soldiers who can immediately return to duty be treated first in order to save units from defeat. Doing so may conflict with medical commitments to saving as many lives as possible. Ethical dilemmas may result. The ministry of guiding and sacramental ministry are beneficial in such situations.

Holding area ministry includes ministry to casualties who are soon to return to duty from the holding area in which they are. It is estimated that as many as 66% of all casualties will be treated at Echelons I and II and return to duty and not be admitted to Echelon III medical treatment facilities.

These holding area patients will require crisis and stress ministry, ministry of guiding, ministry of worship, and sacramental ministry. As seasoned soldiers, they will know the risks and sacrifices of combat duty and have different anxieties than soldiers new to battle.

Soldiers may approach UMTs as "courts of last resort" to intercede on their behalf when they are reluctant to return to duty. UMTs do not make the decision to return anyone to duty. This is always a medical decision, even in the case of battle fatigue casualties, although UMTs may have input into the decision.

The UMT may have ambivalent feelings about soldiers returning to duty whom they know to be battle scarred and who have already "paid their dues" or "been through hell." UMTs out of compassion may want to rescue or save the soldier from further harm. But "rescuing" the soldier may result in thrusting a

newcomer into battle who is not as well prepared as the soldier with "battle sense" and who is a fully integrated member of the unit.

Battle wise soldiers have a better chance of surviving than do new replacements. Lastly, soldiers who are further evacuated when their conditions do not merit evacuation may later have disabling or chronic guilt about not supporting their buddies as they might have done.

UMTs may participate in establishing objective criteria by which to determine who is to return to duty. Capricious policies, or policies so interpreted by soldiers, highly individualized or competitive criteria, and arbitrary decisions will negatively affect morale and may contribute to losing the battle.

Soldiers expect UMTs to assist in establishing and maintaining just and compassionate policies. In study data, one responding chaplain stated forthrightly that it was not his duty to return soldiers to duty, but rather to provide spiritual ministry. But supporting soldiers as they return to combat is unavoidable when UMTs share soldiers' commitments to honorable service to one's country and the freedom of all people for which soldiers fight and die.

The UMTs function is to do its best, so that returning to duty soldiers have faith and other spiritual resources that will sustain them in battle and help them cope with losses that they may experience, particularly if they become casualties again. UMTs accomplish this through providing the previously described ministries.

Nuclear, biological, and chemical warfare presents related yet different requirements for ministry and religious coverage. Mass casualty locations may be within contaminated areas. Evacuation due to required decontamination procedures may be slow. Tactical nuclear weapons will produce casualties with varying degrees of radiation exposure.

Mortally radiated soldiers may be placed in holding areas and those with no other serious wounds even returned to duty during the five days to two weeks of their life expectancy. Mortally radiated casualties may be placed in holding areas with others, or hospices may be established specifically for them in the COMMZ. UMTs will be required to provide the ministry of dying to these casualties.

Considering UMT doctrine, the number of UMTs organic to units within the combat zone, and the number of expected casualties in a high intensity conflict who will be held in holding areas, religious coverage of holding areas is deficient.

Battalion UMTs will be fully required in battalion areas. Combat support and combat service support UMTs in the combat zone will be attending to soldiers in their units, as these units are also vulnerable to enemy attack.

One way to increase coverage is to assign augmenting reserve forces UMTs to divisions to supplement religious coverage to casualties at casualty collection points and holding areas. In the event of mass casualties, one

possibility is to task organize organic UMTs, using them to provide coverage to soldiers of other units with heavy casualties. Brigade, task force, and/or division chaplains could do this task organization.

Distinctive religious group coverage will be difficult on the integrated battlefield, not only because of threat factors which limit movements, but also because of a disproportionate lack of representation by some religious groups and the great number of different religious groups that chaplains represent.

Distinctive religious group coverage can be managed through assigning chaplains of underrepresented groups to area coverage within divisions within the casualty evacuation stream where they will be needed to provide emergency ministrations. Doing so, however, would be impractical, except for those representing large religious groups, such as Roman Catholics.

Roman Catholic priests are also needed in Echelon III and IV medical facilities to provide all types of ministry, including sacramental ministry.

Jewish coverage can be best managed through assigning Jewish chaplains to area coverage responsibilities within corps and collocating them with Echelon III or Echelon IV hospitals, which are in the evacuation chain. Eastern Orthodox chaplains can be similarly assigned and located.

Protestant denominational coverage can be managed through assigning as great of a mix as possible of Protestant chaplains to divisions.

The division chaplain can coordinate specific requests for denominational ministrations as the tactical situation permits. Requests for denominational ministrations from Echelon III and IV medical facilities can be channeled through the corps chaplain with area coverage being provided by Protestant chaplains organic to combat support and combat service support units located in the corps area.

General Rogers' comments about chaplains being more than just representatives of their particular faith needs reiteration whenever distinctive religious group coverage is not practical nor permitted by the tactical situation. All chaplains can provide most of the described ministries, except for a very few sacramental ministrations.

In a staff study conducted in April, 1962, entitled Chaplain's Handbook for Combat, at the U.S. Army Chaplain Center and School, Chaplain Samuel R. Graves, Jr., asked 10 Roman Catholic and 21 Protestant chaplains what they would want chaplains of other distinctive faith groups (Protestant, Catholic, and Jewish) to provide a dying soldier of their group on the battlefield.

The Roman Catholic chaplains responded that they would want Protestant and Jewish chaplains to provide:

- Act of Contrition	10 (No. of chaplains listing)
- God's Mercy, Forgiveness	1
- The Lord's Prayer	1
- Sign of the Cross	1

- Other Prayers 6
- Litany for the Dying 1

The Protestant chaplains responded that they would want Roman Catholic and Jewish chaplains to provide:

- Sign of the Cross 1
- Prayer 13
- The Lord's Prayer 2
- Selected Scriptures 4
- Assurance of pardon 6
- Confess sins 4
- Assure about personal affairs 1
- Baptize if needed 1
- Receive Jesus as Savior 1
- Don't violate his conviction 1
- Comfort him 2
- Notify Protestant Chaplain of action 1
- Make comfortable 2
- Offer to contact loved ones 1
- Help him to die as a man 1

This staff study did not survey any Jewish or Eastern Orthodox chaplains. This study is also dated, although data collected now may be similar.

All chaplains and chaplain assistants provide religious support to casualties according to the dictates of their own consciences and in keeping with the religious tradition that they represent in the military. Religious support to casualties, however, in combat environments transcends religious differences.

RELIGIOUS SUPPORT AS AFFECTED BY UNIT DEPLOYMENT

In light intensity conflicts, in particular, commanders may deploy only portions of units to fight a battle. The deployed force may or may not include the chaplain and/or the chaplain assistant. Frequently, in airmobile engagements, there is not sufficient room in helicopters to include one or both members of the Unit Ministry Team. Consequently, casualties may not receive religious support from UMTs organic to their units.

Commanders may also only partially deploy medical units, often without one or both members of the organic Unit Ministry Team. Casualties may therefore first receive religious support out of country, at offshore collection locations, or in CONUS, as they are evacuated over considerable distances from the point of wounding. This may not be a problem; for often evacuation is relatively quick, usually within a few hours.

In mid-high intensity conflicts, casualties may also be evacuated relatively quickly, bypassing some casualty collection and ambulance exchange points, and at times even some corps hospitals.

Corps and other chaplains in rear areas need to be alert for casualties evacuated to rear areas who have not received any religious support prior to their evacuation. Medics may place these casualties in holding areas to await further evacuation to CONUS.

The Air Force does provide some religious coverage to the Mobile Aeromedical Staging Facility (MASF) at which casualties are held ideally only for 3-5 hours before evacuation to CONUS.

ECHELON III RELIGIOUS SUPPORT TO CASUALTIES

UMTs provide each of the described ministries in Echelon III medical facilities. The type, number, and mix will vary as battlefield scenarios, evacuation capabilities, and the intensity of the conflict varies.

In light intensity conflicts, mortality and morbidity rates are expected to be lower than in mid-high intensity conflicts. Mortality and morbidity rates are also lower if casualties receive immediate far forward medical treatment and if evacuation to required levels of treatment is rapid.

UMTs provide the ministry of presence to all patients admitted to Echelon III hospitals. Chaplains' being present symbolizes to casualties God's loving presence and identification with suffering. Chaplains symbolize transcending realities, meanings, spiritual values, and religious resources for coping with the trauma of battle. Chaplains may symbolize strength, composure, comfort, and peace. Chaplains are symbols of faith. Some soldiers project upon chaplains powerful authority to intercede for them before God.

Soldiers may also view chaplain assistants as symbols of faith, although chaplain assistants are not in the military to represent specific religious groups.

In the Roman Catholic Church, only ordained priests have the authority of priests, even though Lay Eucharistic Ministers may be authorized to distribute the sacrament known as the Eucharist. In both Roman Catholic and Eastern Orthodox churches, only priests can forgive sins. In some Protestant denominations, only ordained or clerical members can distribute Holy Communion.

These differences in authority together with functional differences between chaplains and chaplain assistants within the military influence what symbols soldiers project upon chaplains and chaplain assistants.

A religious needs assessment best precedes other previously described ministries. UMTs assess patients' religious needs, spiritual conditions, and religious resources in this process. The Unit Ministry Team determines what type of religious support would be best for each casualty. This may vary from a brief friendly contact to frequent in depth pastoral counseling.

The type of religious support provided is related to patient conditions. The amount of religious support provided depends upon the time and availablity of Unit Ministry Teams within Echelon III hospitals.

UMTs provide the ministry to the dying to all casualties evaluated by medical treatment personnel as dying, to those suffering life threatening conditions, to those preparing for death, or to those who perceive death as a real possibility.

TAA 93 projects that only 1% of all casualties admitted to Echelon III medical treatment facilities or 780 patients will die in that echelon, although some project that as many as 2-3% may die in hospitals. TAA 93 also projects that patients in 28 different patient classifications may die.

Approximately 18% or 20,535 patients of all casualties admitted to Echelon III may be in patient classifications which may be life threatening. Many others may perceive that their deaths are imminent when they are not. These casualties need to be assured of their survival by someone whom they trust.

Computer models project that 9.5% or 10,843 patients who are admitted will be unconscious during part or all of their stay in Echelon III medical facilities. Their inability to communicate will limit the type of religious support provided. However, UMTs can provide emergency ministrations. And verbal reassurance and touch can be supportive to those marginally aware of the presence of others. Both silent and verbal prayers which invoke God's healing presence and help have power to aid healing and stabilization.

UMTs provide a ministry of sustaining to those for whom healing or restoration to former conditions of wholeness are remote, impossible, or at least not in the near future. These patients' conditions will not soon or ever change very much.

Included are amputees, paraplegics, quadriplegics, the disfigured, those with disabling brain or organ damage, and those who must use machines to continue living. Those with other permanent disabilities, those in continual pain, and those whose suffering is relentless may also benefit.

TAA 93 projects that 6.4% or 7,346 of those casualties admitted to Echelon III hospitals may be amputees. It is projected that approximately 3.7% or 4,272 patients will be suffering from burns which may require lengthy treatment and/or be permanently disfiguring or disabling.

Approximately 18.1% or 20,649 patients will be evacuated from theater who will have permanent disabilities. Approximately 39.1% or 30,680 will require medical treatment of more that 90 days. And 34.2% or 26,883 will require medical treatment for 61 to 90 days.

UMTs provide sacramental ministry to those requesting distinctive religious group ministrations. The number who will request this ministry is difficult to estimate.

In the study of surgical, evacuation, and field hospital chaplains in Vietnam, all chaplains responding reported that many soldiers requested sacramental ministry. Six out of seven listed sacramental ministry as the first or second most requested ministry. All chaplains provided this ministry within the constraints of their own theological traditions.

When asked how hospital ministry was viewed, either as counseling or sacramental, three out of seven chaplains chose sacramental. All chaplains except one perceived soldiers' religious needs to be over and above denominational requirements.

UMTs provide crisis and stress ministry primarily to those suffering battle fatigue. Because battle fatigue is best treated far forward in Echelons I and II and in non-medical settings in Echelon III, only 3.1% or 3,540 combat stress reaction casualties are projected to be admitted to Echelon III hospitals. Another 7.4% or 8,268 casualties may be classified as having neuropsychiatric conditions, which may or may not be related to the trauma of battle.

Other casualties who may benefit from this ministry are patients with severe burns, approximately 2.1% of the total admitted or 2,339. UMTs also provide this ministry to pre-surgery patients, in particular those who are apprehensive. Approximately 74.8% or 85,267 patients may require surgery in Echelon III medical facilities.

One study has discovered that pastoral ministry prior to surgery significantly reduces recovery time. A minister stopping by to say hello reduces recovery time by an average of 0.6 days. Sharing prayer and scripture reduces recovery time by an average of 1 day. Recovery time for those believing in God averages 2 days less. The study concludes that good pastoral care can reduce recovery from surgery time by as much as 20%.

This ministry is also beneficial for the 25.7% or 29,306 patients who are suffering from multiple fragment wounds. Multiple trauma patients frequently are anxious about whether or not they will survive. They may have difficulty coping with the horror of their wounds or their experience of being wounded.

UMTs provide the ministry of guiding to patients who are reevaluating their values, experiencing moral and ethical dilemmas, having interpersonal and intrapersonal conflicts, and contemplating major decisions.

Frequently, wounded soldiers reevaluate their values after they are wounded. They may question the values for which they sacrificed. They may request assistance in reordering their priorities. What may have previously seemed unimportant is now important.

Once wounded, casualties may value their families more. They may also reevaluate their behavior. They may regret past actions. They may look for support to change their lifestyle. They may seek new directions for their lives, especially if they must now live with a permanent disability.

Hospitalization provides casualties time to think without distractions used previously to escape important issues. They often seek someone to listen, with whom to reflect and share their ideas and feelings. They request a ministry of guiding.

The number who will request this type of religious support is difficult to estimate. In the study of surgical, evacuation, and field hospital ministry in Vietnam, four out of seven chaplains responding viewed hospital ministry primarily as a counseling ministry.

Much of Vietnam hospital chaplains' counseling was with patient care staff, particularly as they confronted morality, alcohol and drug abuse, and

interpersonal issues. Some informally led staff support groups. Ministry to the staff providing medical care for casualties is often one of the top priorities for religious support within hospitals.

UMTs provide a ministry of worship to Echelon III patients individually, in patient care wards, in dining facilities or other shared areas, and occassionally in available chapels.

Approximately 85.7% of all return to duty category and 33.9% of evacuation category patients in Level III hospitals are ambulatory. As many as 60% of all intermediate care ward beds and 100% of minimal care ward beds are occupied by ambulatory patients.

Using mean values for beds occupied, TAA 93 projects that as many as 4,393 return to duty patients and 3,049 evacuation category patients would be able to attend corporate services of worship each day in Echelon III medical facilities. These numbers do not include the mean of 10,927 ambulatory patients occupying hospital holding company beds which are collocated with medical treatment facilities. UMTs also provide the ministry of worship to patient care staff, either with patients or separately.

UMTs provide the ministry of celebration to those patients who are celebrating their survival, that their wounds are not more serious than they are, and battlefield wins.

One Vietnam era chaplain, Chaplain James Shaw, remembered one evacuation hospital patient who celebrated that he had lost only a foot and not a leg.

The ministry of celebration is a ministry of joining with patients in their joys and facilitating opportunities to thank and praise God and others for their contributions to their well-being.

ECHELON IV MINISTRY TO CASUALTIES

Religious support provided in Echelon IV medical facilities is similar to that provided in Echelon III. The major difference is that patients evacuated to Echelon IV are being evacuated for further stabilization or treatment prior to return to CONUS. The number and mix of direct admissions to Echelon IV hospitals will be similar, as will the ministry to each category of casualty.

Using mean values, approximately 67% of Echelon IV patients or 7,306 patients will be ambulatory. TAA 93 projects 9,317 direct admissions to Echelon IV hospitals, of which 44.5% or 4,150 will be evacuated. It is projected that only 23 patients will die in Echelon IV medical facilities during the first thirty days of a mid-high intensity conflict in Europe.

MANPOWER CRITERIA FOR RELIGIOUS SUPPORT TO CASUALTIES

The basic UMT MARC has four criteria: one chaplain per 700 soldiers, or major fraction thereof, dispersion on the battlefield, and mission.

The Vice Chief of Staff, U.S. Army, accepted these criteria most recently at the Personnel Service Support, Combat Service Support Systems Program Review, 11-12 June 1986, Fort Benjamin Harrison, Indiana. Thus "the MARC is square."

This basic UMT MARC provides minimum religious coverage for religious support to casualties in Echelon I. If the treatment squad is divided into two teams and located at two locations, the Unit Ministry Team organic to the battalion must move among these two points in addition to other locations to provide ministry to all soldiers, including casualties. The Unit Ministry Team cannot preposition itself as in the past at the battalion aid station. Doctrine is deficient in suggesting this.

Augmenting forward treatment points with brigade assets would deprive brigade units and soldiers of religious coverage and detract from brigade UMT support to the entire brigade. Casualties not receiving religious support at forward treatment locations may receive essential religious support at the brigade clearing station.

Distinctive religious group coverage, namely Roman Catholic coverage, can be provided by one of the three Roman Catholic UMTs projected to be assigned in support of each division, but only as the battlefield situation and units' military mission permit.

Unit Ministry Teams organic to division headquarters provide for religious coverage to the division clearing station during the battle phase.

Not covered in Echelon II are patient holding areas for return to duty category casualties who will be held from 1 to 7 days in the Combat Zone. One possibility is to assign this responsibility to the division support command UMT.

Casualties admitted to Echelons III and IV medical treatment facilities will receive essential religious support from UMTs organic to medical units and augmenting UMTs who provide area and distinctive religious group coverage.

Current manpower standards for hospitals are based upon the number of beds occupied. Current civilian standards adopted by the College of Chaplains recommend one chaplain for the first 50 beds and one additional chaplain for each additional 100 beds.

A nonapproved MARC study for the Hospital Chaplain completed in 1983 recommends 0.016 chaplains per intensive care bed, 0.006 chaplains per intermediate care bed, 0.005 chaplains per minimal care bed, and 0.001 chaplain per staff member or assigned soldier. These standards can no longer be used, as the number of assigned staff members is now related to patient conditions.

A new MARC Development Plan was approved on 31 December 1986 to develop manpower criteria for hospital UMTs. This study will be completed in FY 88.

Using TAA 93 projections for a 20 division NATO force during a 30 day time period, the number of Unit Ministry Teams required to provide the previously described religious support can be determined.

If chaplains provide described religious support 9 hours per day and chaplain assistants assist chaplains in providing the described direct religious support to casualties for 5 hours per day, the total number of UMTs required to provide minimum essential religious support in Echelon III medical facilities is 77, or approximately 4 UMTs per division. This number does not take into account requirements for distinctive religious group support.

Chaplains will be involved in other activities during the remaining 3 hours of each duty day. These include: staff ministry, staff activities, administrative duties, unit support activities, and professional development.

Chaplain assistants will be performing other duties which do not bring them into direct contact with patients, but which are essential to religious support. These include: preparing for religious services, surveying and identifying both unit and individual needs for religious support, training others in peer ministry, and managing appropriated and non-appropriated funds.

Chaplain assistants also provide administrative support, coordinate religious activities, provide security for religious activities, arrange for transportation when necessary, maintain records of religious support provided, requisition and manage supplies, maintain equipment, participate in unit training and other activities, and otherwise support the unit's mission.

The number of hospitals that will be assigned to support each division, their type, and how many beds each will have are yet to determined. To support 14,119 patients, the mean number of beds required each day, as projected by TAA 93, would require 56.48 Echelon III 250 bed hospitals or 47.06 Echelon III 300 bed hospitals. This would not satisfy peak requirements which are projected to be 3-5% higher. Adding 5%, the requirements would now be 59.3 Echelon III 250 bed hospitals and 49.41 Echelon III 300 bed hospitals.

Ideally, each hospital would have two chaplains, one Protestant and one Roman Catholic. Requirements would then be 118 UMTs for 59 hospitals (250 beds each) or 98 for 49 hospitals (300 beds each). This would also make around the clock religious support possible.

Hospital holding areas are projected by TAA 93 to contain a mean daily number of 10,927.70 patients or 184 patients for each 250 bed hospital or 223 patients for each 300 bed hospital. Projecting 5 minutes per pastoral visit once every 3 days during the average length of stay of 9.21 days yields a mean daily religious coverage requirement for 9.89 UMTs.

The Echelon III MASH type hospital receives its religious coverage from a UMT organic to the unit. If these are assigned 1 per division, the total

number of required UMTs for Echelon III MASH type units for a 20 division NATO force is 20 Unit Ministry Teams.

If 2 chaplains are assigned to each of the other Echelon III medical facilities, these UMTs could augment religious coverage in the MASH, providing any distinctive religious group coverage that the UMT organic to the MASH cannot provide.

In the study of chaplains assigned to hospitals in Vietnam, MASH chaplains indicated that 1 UMT per MASH was adequate, but that providing around the clock religious coverage and distinctive religious group ministry was not possible without augmentation by other UMTs.

ECHELON IV MANPOWER CRITERIA

The primary medical facility in Echelon IV is the General Hospital. It is projected to have approximately 500 beds. It receives some direct admissions from corps and echelons above corps, but most patients will be those evacuated from Echelon III medical treatment facilities who need additional stabilization prior to evacuation to CONUS.

The mean daily number of beds occupied is projected by TAA 93 to be 10,904.83, requiring no less than 33 General Hospitals (500 bed). The percentage of evacuation category patients will be higher than in Echelon III because most of those evacuated from Echelon III medical facilities will receive some treatment in Echelon IV prior to evacuation to CONUS.

The number of deaths in Echelon IV medical treatment facilities is projected as 23. The percentage of surgeries will be much lower, as most required surgery will be performed in Echelon III. Approximately 67% of the Echelon IV patients will be ambulatory.

Therefore UMTs will primarily provide the ministry of sustaining, sacramental ministry, the ministry of guiding, ministry of worship, and ministry of celebration.

If UMTs provide each Echelon IV patient the previously described religious support according to Echelon III standards, the total number of Unit Ministry Teams required to provide this religious support is 77 or approximately 2 per General Hospital.

RELIGIOUS SUPPORT TRAINING REQUIREMENTS

FOR MINISTRY TO CASUALTIES

The Army cannot assume that either chaplains or chaplain assistants are prepared to provide combat religious support to casualties. Even many well-trained Unit Ministry Teams are not prepared for the stresses, the horrors, the trauma, and the suffering that they will experience on the modern integrated battlefield.

Training in field environments for Unit Ministry Teams today seldom includes training in religious support to casualties, even when UMTs do perform casualty play with aid stations. Seldom are "casualties" for treatment at these aid stations prepared using the moulage techniques that are so much a part of training medical teams in mass casualty exercises.

Chaplain Emory Cowan, an experienced combat, hospital, and hospital ministry training chaplain, writes:

> We should not be deluded into thinking that ministry to troops in the field is analogous to ministry to troops in combat. The issues are not the same. The presence of mutilated bodies, the smell of burnt flesh, confrontation with hollow-eyed, disoriented troops, and the fleeting awareness that one's own life could be terminated, make the field exercise seem like a church picnic.

Chaplain Cowan also points out that collective combat experience in the chaplain branch is rapidly diminishing, as many chaplains who served in Vietnam have now retired. Relatively few chaplains now on active duty have experienced the highly lethal environment and the mass casualties of a modern battlefield.

Some chaplains who were in Vietnam or Granada were not directly exposed to battlefield casualties. Younger chaplains, who are the ones who would be assigned most forward on the battlefield, are those who most lack experience. Only a few have prior military combat experience or have participated in mass casualties in civilian life.

Neither can the Army assume that chaplains' civilian education has prepared them for combat ministry to casualties. No civilian theological seminary or school is known to offer a course in combat ministry. Most seminaries and schools do, however, offer courses in hospital ministry which discuss trauma ministry. Some of these courses include experiential learning in a medical treatment facility.

Many seminaries do require one quarter of Clinical Pastoral Education, an experiential learning process which may be received in a hospital, but which also may be received in settings such as a prison, a mental hospital, a counseling center, or a parish outreach program that does not expose participants to medical trauma casualties.

No military chaplain or civilian theologian has ever suggested that ministers or anyone else can be fully prepared for what they will experience on the battlefield.

In the aftermath of the San Diego airplane crash on 25 September 1978, Dr. Alan Davidson, a clinical and forensic psychologist, discovered that many attending veteran police officers had disabling post-traumatic stress reactions following the disaster.

However, this does not mean that the Army cannot establish training programs which will lessen the effects of battlefield trauma and assist UMTs to prepare for ministry to casualties.

Military chaplains have developed several training programs. They have suggested others.

One of the first was a one day orientation to hospital ministry conducted by Chaplains Alcuin Greenberg, Al Delossa, and Emory Cowan at Fort Ord, California, in 1978. One of the objectives was to desensitize participants, all first-term chaplains, by requiring them to witness a surgical procedure. Eight of the twelve participants felt faint or nauseated. Some left the operating room. One refused to participate.

One chaplain told this writer that he feels faint and gets sick whenever he enters a hospital. A chaplain cannot provide selfless ministry to casualties in this condition. Thus one of the training needs is for desensitization training, if UMTs are to provide religious support to casualties on the battlefield.

Responding to this need and as a result of his previous experience, Chaplain Cowan developed a two week course in September, 1979, at Brooke Army Medical Center at Fort Sam Houston, Texas, entitled "Trauma and Survival."

The goal was to assist chaplains to draw on some basic resources that would aid them in surviving spiritually and emotionally in the presence of trauma. The three stated objectives were:

1) To prepare the chaplain affectively and cognitively for ministry in combat and mass casualty situations.
2) To help the chaplain focus and clarify his own responses to trauma and high stress.
3) To assist the chaplain to discover means within himself to cope with trauma and to continue to function as a representative of God.

Learning settings included the Institute for Surgical Research (the hospital burn unit), Surgery, Anatomical Pathology, and the Emergency Room.

These settings not only introduced participants to medical procedures in which they would see and smell blood, patients burned beyond recognition, and both live and dead bodies receiving surgical treatment, but also confronted

them with their own finitude. Their experiences, thoughts, and feeling responses were then confidentially discussed in small support groups.

This program produced many positive results. Participants discovered personal and spiritual resources for coping with trauma. Others discovered new meaning for their lives and ministries and new understanding of their relationship with God.

Participants discovered that they needed to vent their anger, share their fears, hurts, and frustrations, and unconditionally accept one another. Several identified it as an experience of grace and healing. Their faith, supporting belief systems, and values were challenged, and they survived spiritually and emotionally in the face of trauma.

Chaplain Jay Ellens, the editor in chief of the Journal of Psychology and Christianity and the Executive Director of the Christian Association for Psychological Studies International, has proposed four key areas in which chaplains must be prepared if they are to minister effectively in combat.

First, chaplains must be spiritually prepared. Noting that many of the hundreds of chaplains to whom he has spoken have "extremely superficial" rationales and philosophical systems for "holding up" in mass casualty situations, he writes:

> Most do not really comprehend what an experience of that extremity will be like in actual fact and have extremely simplistic notions of what a theological world-view really is, what a coherent and comprehensive ethical system really is, and what the crucial importance of both are for making sense in the potential holocaust we face.

Chaplains must be able to maintain wholeness, hope, meaningfulness in ministry, trust, fervency, and assurance of God's unconditional grace to survive in the face of trauma.

Second, Chaplain Ellens stresses the importance of theological preparedness or having:

> ...a profound and carefully worked out theological world view in which mobilization, war, mass casualties, and NBC environments involving masses of civilians as well as soldiers can be accounted for satisfactorily, and and coherently explained, experienced, and integrated smoothly into meaningful thought and feeling. That will be possible only if the chaplains are trained to be relatively sophisticated in theological concepts and faith insights. Only in a theological world-view which affords meaning to human suffering, inhumaneness, and irrationality, in a way that neither jeopardizes the integrity of God in his grace nor further demeans suffering humans by assigning some sort of equivalency or cause and

effect relationship between our guilt and our pain, will chaplains find a sufficiently durable faith perspective as to survive mobilization and war without hopelessness, depression, or psychotic breakdown.

Third, Chaplain Ellens stresses the importance of ethical preparedness. Chaplains must embrace as an ethical imperative their being wherever there are suffering people in need, regardless of whether or not the cause seems ethical to them.

Chaplain Ellens views war as always immoral and as the lesser of two monstrous evils to which responsible people are sometimes driven. The ultimate pastoral question is what chaplains should do with wars in responsibility and godliness. He concludes that chaplains must be there to minister to those who are suffering.

Fourth, Chaplain Ellens stresses the importance of psychological preparedness. The goal is to have stable, resilient, and concerned chaplains who understand themselves, can respond to and with feelings, can creatively manage anger, anxiety, stress, and depression, and who can provide mutual support to other chaplains as colleagues.

In conclusion, Chaplain Ellens reiterates the importance of adequate theological world-views, spiritual rationales, ethical perspectives, and psychological stability to "get through" the combat experience. He suggests that chaplains can be more than rescuers of the miserable. They can also be ethical guides in constructing a moral universe in the midst of a seemingly immoral environment. They can assist in building the Kingdom of God.

Chaplain Douglas Larson, a Navy chaplain, in an unpublished paper dated 31 May 1985, suggested a program for combat training of Navy chaplains. His suggestions are based upon his experience of a one day training event on 14 March 1984, in which participants were introduced to some of the frightful aspects of combat ministry to casualties through the use vivid photographic slides.

Presentations were made on the types of medical combat casualties, the types of psychiatric casualties, the health care team, ethical dilemmas and triage, techniques for ministry in combat medicine, and the function of the chaplain in combat. Whereas this seminar introduced the issues, Chaplain Lawson evaluated it as lacking opportunities for "hands on" training, role play, and sufficient discussion.

Chaplain Lawson suggests a course similar to the Brooke Army Medical Center program, "Trauma and Survival." He suggests training chaplains in medical treatment facilities that have large numbers of trauma patients, including a burn ward. Recent experience in the Navy in which there have been several serious fires on board ship to which chaplains have responded make training in ministry to burn patients essential.

As an alternative, Chaplain Lawson suggests expanded one day events in combat ministry to casualties to be conducted at the Naval Chaplain School. Or

chaplains could be assigned to emergency rooms of hospitals in Providence, RI, or Boston, MA, as part of their training. He concludes, "While nothing short of the actual event approximates the combat experience, it is possible to at least rehearse for the battlefield environment."

Each of these programs or proposals identifies a need for experiential training in combat ministry to casualties.

The existence of more than 500 Clinical Pastoral Education programs conducted in hospitals and medical centers is further verification that many civilian clergy and their teachers recognize the importance of pastoral training in a trauma center.

The Army can also give more attention to training Unit Ministry Teams in field environments, using realistic training aids, and encouraging them to be involved in casualty play at aid stations. They can respond "as if" they were in combat, as others do.

Chaplain (MG-Ret) Patrick J. Hessian, in a letter to all Army chaplains, dated 1 September 1985, when he was Army Chief of Chaplains, wrote:

> I feel very strongly that when chaplains go to the field with their units, they must be concerned much more than with a "ministry of presence", or simply "talking with soldiers," demonstrating a willingness to share the hardship or conducting religious services. They must prepare and train the Unit Ministry Team (UMT) to carry out the entire program of ministry in a hostile, fierce combat environment.

Unit Ministry Teams are now being trained and will have a larger role in preventing and treating battle fatigue, a ministry now articulated in FC 16-51. Standarized training and evaluation is also being developed for UMTs training at the National Training Center at Fort Irwin, CA. And in July, 1985, the U.S. Army Soldier Support Center fielded a new ARTEP Personnel Service Support Common Module, in which Chapter 7 describes the mission of the battalion chaplain.

Approximately 15% of all chaplains or 10-12 chaplains per year do receive Clinical Pastoral Education in medical treatment facilities, usually in their 6th to 9th year of military service. Since this training qualifies them for validated hospital ministry positions, most have follow-on assignments in military hospitals.

Training so few chaplains specifically in trauma ministry or in trauma settings is a deficiency which must be corrected if casualties are to receive the best possible religious support and the ministries previously described in this study.

Many of these training requirements are also applicable to chaplain assistants. As fighting forces become increasingly more austere, chaplain

assistants will become increasingly involved in providing direct religious support to casualties.

One division chaplain, responding to the question of how chaplain assistants can be used in casualty care, forthrightly declared that the chaplain assistant is not in the casualty care business. But others foresee chaplain assistants being used to support the chaplain, screen casualties for the chaplains, listing priorities, identify critical casualties, provide stress management, be a medic, conduct triage, be a casualty monitor, and identify and locate casualties.

Thus nine out of ten division chaplains foresee chaplain assistants coming into contact with casualties, if not providing religious support There is no known data of how chaplain assistants were used in providing religious support to casualties in previous wars.

Just as congregational lay leaders do not usually have the theological sophistication that pastoral leaders do, and behavioral science specialists do not have the same skills as the psychologists who supervise them, neither is it expected that chaplain assistants have either the theological sophistication nor the counseling skills that most chaplains have.

This does not mean that chaplain assistants cannot provide valuable lay religious support to casualties, especially if they are trained and supervised, and their religious support is coordinated with that of chaplains'.

One of the most valuable functions for which chaplain assistants can be trained is to do the religious needs assessment of patients being admitted. Performing this "religious triage" frees the chaplain to provide religious support where it is most needed and ensures that all casualties receive religious coverage.

In order for chaplain assistants to serve this function, most will require some desensitization training. They will be meeting casualties in triage areas. They will see death, mutilated bodies, open wounds, blood, massive burns, amputations, emergency surgical procedures, and many other horrors of battle.

The Army can also train chaplain assistants to provide a ministry of sustaining, a ministry traditionally provided by lay persons. They can stay with the dying so they are not alone, can provide acceptance for those with permanent disabilities, and be someone with whom to share the silence for those who are suffering.

Since someone being there is often more important than what is said or done, they need only an understanding of the value of this ministry and the ability to cope with their own intruding feelings in order to provide this ministry. Sharing this ministry with chaplains, chaplain assistants free chaplains to be with others who need other described ministries.

Chaplain assistants are trained to support religious services and perform the administrative duties that are essential to religious coverage. They can

be trained to keep accurate records of ministries provided, supporting manpower requirements. They can be trained in listening skills, crisis intervention, and to provide small group studies.

Chaplain assistant Soldier's Manuals list many more functions which are essential in supporting the best possible ministry to casualties.

Fifteen to twenty chaplain assistants are being trained each year during a one week program at Brooke Army Medical Center, Fort Sam Houston, TX, to provide direct religious support to patients. Ward visitation and exposure to trauma are integral parts of this program.

Training Unit Ministry Teams together has been frequently proposed. Whereas some chaplains think that training chaplains and chaplain assistants together would blur functional distinctions between chaplains and chaplain assistants and interfere with supervision, others think team training would increase overall effectiveness.

As UMTs train together, they would discover each other's talents as well as each other's needs. They would learn to trust one another. Whereas this usually happens over a period of time as members of a team work together, placing them in the crucible of trauma settings would speed the process of their realizing their potential as a team. Thus training UMTs together has merit. A pilot program should be undertaken.

SECONDARY UNIT MINISTRY TEAM FUNCTIONS

According to AR 165-20, paragraph 3-6:

> Commanders will detail or assign chaplains only to duties related to their profession. Chaplains may perform unrelated duties in a temporary military emergency. Chaplains may volunteer to participate or cooperate in nonreligious functions that contribute to the welfare of the command.

In an "austere, but adequate" health service support system designed and staffed to provide medical treatment to combat medical casualties using mean values rather than peak values to establish patient workload requirements, there will be casualty situations in which there will not be enough medical treatment personnel available to provide the medical treatment required to save lives.

Due to the lethality of modern weapons, soldiers being widely dispersed on the battlefield, and projected shortages of medical treatment personnel, a Heritage Foundation study has projected that as few as one in ten wounded soldiers on a large scale conventional battlefield would received medical aid. The Association of Military Surgeons in 1985 projected that only 25% of the wounded would receive life saving combat surgery.

Increasing the number of medical treatment personnel is the surest way to correct these deficiencies. However, increasingly, Army combat developers are

reducing both the number of medical treatment personnel and units, replacing them with combat arms personnel and units to fight battles with the most austere force.

Medical combat developers have therefore proposed as a corrective increasing soldiers' proficiencies in first aid. They emphasize both self aid and buddy aid. They have further proposed training one soldier per squad, usually a junior non-commissioned officer or assistant section leader, in additional life-saving skills.

The additional "combat lifesaving" skills include: managing the airway, performing one man cardiac pulmonary resuscitation (CPR), initiating and maintaining an IV, restoring breathing in a chemical casualty, managing battle fatigue, and transporting a casualty using a military vehicle.

Austere health service support also includes using physician assistants, dentists, and medical non-commissioned officers under physician supervision to perform triage and be "extenders" of medical care on austere battlefields. And every soldier must be proficient in first aid.

Unit Ministry Team doctrine places UMTs forward with maneuver units on the AirLand battlefield. UMTs will be with soldiers both at points of wounding and at casualty collection points shortly after wounding.

UMTs may be among the first to provide first aid to save lives, may assist others in providing first aid, and may be required to assist combat medics or other medical treatment personnel in such varied functions as retrieving the wounded from the battlefield, carrying the wounded, holding pressure points to control bleeding, holding IVs, perform CPR, and managing battle fatigue at the same time that they are providing religious support to casualties.

In order to serve this secondary function better, Unit Ministry Teams could be trained either as combat lifesavers or combat medics.

Whereas according to AR 165-20, para. 3-6, chaplains can only be assigned to duties related to their profession, they "may perform unrelated duties in a temporary military emergency." And chaplains "can volunteer to participate or cooperate in nonreligious functions."

Chaplains who want to be prepared for temporary military emergencies including lifesaving on the battlefield and/or those who volunteer would therefore desire proficiency training as combat lifesavers or medics.

Chaplain (COL) Reinard W. Beaver, Chief, Department of Ministry and Pastoral Care, Madigan Army Medical Center, Tacoma, WA, proposed in a letter dated 17 February 1983 to the Health Services Command Chaplain that chaplains and chaplain assistants receive:

- Training in basic life support skills per skills manual of 91 B MOS (combat medic)
- Triage training

- Schooled in concept of "vital signs" and "range" from normal to abnormal
- Assess embedded objects such as shrapnel and cautions pertaining to extraction of such objects driven into the body by the blast

Chaplain Beaver further recommended establishing an additional specialty skill index (ASI) and justification for special training requirements.

When division chaplains were asked what action they prefer when placed in a life/death situation at the point of wounding or at the battalion aid station with no medical treatment personnel present, the first choice of 7 out of 10 was "first aid." One replied "lifesaving." One replied, "go for medic." And one replied, "all - pray, go for medical aid, first aid."

All division chaplains recommended that UMTs be familiar with lifesaving skills. Six out of ten division chaplains said that their chaplains were proficient and/or experientially familiar with combat lifesaving skills. One division chaplain reported that his chaplains had received "extensive" training in first aid.

None of the division chaplains' responses can be interpreted as suggesting or recommending that UMTs be trained as either combat lifesavers or medics. In response to one other question in which division chaplains were asked how they foresee the chaplain assistant being used, one did respond "medic." This same chaplain responded "first aid" to the previous question.

Five out of the seven hospital chaplains who served hospitals in Vietnam responded that they did not perform secondary functions in emergencies in their hospitals.

Occasionally, they reported assisting litter bearers. Three reported restraining a patient. One reported to being an extra set of hands in the emergency room. Two chaplains did reply that they did perform "all" the functions listed: restraining a patient, clearing an airway, applying pressure bandage on bleeding, bathing a wound site, assisting in minor surgery, washing a patient, running an errand for medical personnel to obtain blood.

Modern battlefields present UMTs with a dilemma. What is their function in providing religious support to soldiers, particularly when soldiers become casualties? How can they be best used? On the one hand, saving lives is essential. UMTs can be trained to save lives.

On the other hand, the UMT's mission is to provide religious support. UMTs are there to witness to God's caring presence and identification with suffering. They are there to pray with and for soldiers. They are there to calm the anxious, comfort the afflicted, and strengthen the weak with words of faith.

Is it possible that UMTs could provide both religious support and medical care? Many medical missionaries do. Historically, some chaplains have bound wounds in addition to providing religious support to soldiers on the

battlefield. If they did both, perhaps some who now perceive them as "excess baggage" on the battlefield would no longer so perceive them.

Unit Ministry Teams do augment medical treatment in providing support to battle fatigue casualties. Positioned far forward of medical combat stress control teams, UMTs provide a resource beyond that of combat lifesavers or medics in managing battle fatigue.

Chaplain assistants assist chaplains to identify battle fatigue casualties. Chaplains provide crisis and stress ministry as previously described. This religious support parallels and complements medical management of battle fatigue casualties, but does not replace it. It is further described in FC 16-51.

It is this writer's opinion that on an austere battlefield, UMTs providing medical treatment beyond first aid would so consume the UMT's time, energies, and talents that it would quickly become a primary function and seriously limit essential religious coverage and support.

UMTs as a relatively scarce resource would be limited in moving from casualty to casualty, providing required religious support to all soldiers. Some may become so involved in medical care that they neglect to pray, share words of faith and hope from sacred writings, and witness their faith.

Furthermore, it is this writer's opinion that those chaplains who most want to become involved in providing medical treatment are those who lack pastoral identity, who undervalue the importance of their presence as symbols, their prayers, and their witness, and who are experiencing their own crises of faith.

Chaplains are not immune from struggling spiritually or having doubts, especially in times of great suffering and moral uncertainty. It is when chaplains are struggling that they are most vulnerable to adopting secondary functions, interpreting them as ministry, and undervaluing spirituality as a resource. Good supervision, supportive colleagues, and spiritual guidance can assist struggling chaplains in revitalizing their faith perspectives.

UMTs must be proficient, as all soldiers must be, in first aid. Familiarization with other life-saving skills is also recommended.

Not recommended are training or designating UMTs, either chaplains or chaplain assistants, as combat life-savers or medics. The UMT's mission is essential to soldiers' coping with the trauma of battle. It must never be diluted by secondary functions, no matter how important they may be. Chaplains do not bear arms for this reason. The UMT's primary function on the battlefield is always to provide religious support.

RELIGIOUS SUPPORT TO MEDICAL TREATMENT PERSONNEL

The Unit Ministry Team's religious support to casualties also includes providing religious support for those providing medical treatment for casualties.

Combat medics suffer one of the highest rates of death of all military specialties. One combat medic who was interviewed reported that more than one half of his combat medic class (91B) of more than 150 students was killed in Vietnam. Ten nurses also died in Vietnam, 7 in aircraft accidents, one of a subarachnoid hemorrhage, one of disease, and one of shrapnel wounds suffered in a mortar attack.

All medical treatment personnel are subject to becoming combat casualties; for battlelines in both light intensity and mid-high intensity conflicts are not projected as being clearly drawn. Medical units, including hospitals, will be subject to rocket and mortar attacks, air attack, guerrilla warfare and terrorism, and NBC attack. Fears of attack, helplessness, and inability to function will be common, as in other wars.

Working conditions also may not be ideal. Many medical personnel in Vietnam described their work as "dirty, long, ugly, and dangerous." James Odom, a combat nurse, writes of times when they had no electrical power because the generator was broke, no drinking water because the water truck was broke, and no beverages because the PX had been hit by mortar fire. He reports "living in dirt."

J. Wilson in testimony before the U. S. Senate Subcommittee on Veteran Affairs described the work as filled with "unrelenting experiences of constant casualties, mangled bodies, 24-hour shifts, God-like medical decisions about treatment, and a daily experience of the death of young boys."

Frances Shea writes about how unprepared she was for the catastrophic casualties who came into her operating room. Her initial feelings were shock, disbelief, hurt, and anger.

Staffing in Vietnam was often austere, as it is expected to be in future conflicts. Odom reports that his Medical Unit, Self-contained, Transportable (MUST) unit had 14 nurses, 12 doctors, 4 administrators, 1 dentist, 1 chaplain, and 122 enlisted personnel. They worked 12-hour shifts.

Medical treatment personnel who served in Vietnam report experiencing all the spiritual conditions previously described. Many experienced crises of faith, grief, guilt, fear, and despair.

Traumatic events profoundly disrupted their basic assumptions about personal safety, self-image, and the meaning of their worlds. They struggled to find meaning in their experiences. "Fatigued by the work and overwhelmed by the emotional impact of events, many were unable to integrate their experience and maintain psychological equilibrium," write Barbara Rogers and Janet Nickolaus.

Some medics lost confidence in and became suspicious of authority figures. The sheer horror of their experience and the youth of the casualties eroded much of their initial sense of mission. Some were disappointed and felt betrayed by the ideals and values of their communities and families. Some felt that even God had abandoned them.

Some experienced their self-concepts changing. Socialized to be caregivers and to preserve lives, many had feelings of wanting to kill the enemy or even "pull the plug" on wounded enemy soldiers for whom they cared.

Many grieved, even though many reported that they had little time to grieve. They grieved being the last persons dying persons would ever see, which has been identified as a major stressor. They grieved the rather abrupt termination of relationships with patients, as they were evacuated and never heard from again, and with other staff, as staff rotated in and out. One nurse suffered anticipatory grief, as he worried about the pain that his death would cause his family.

Medical personnel reported suppression of affect, becoming numb, not forming close relationships, withdrawal, and escapist activities as ways to cope with the grief experienced.

Many medical treatment personnel experienced guilt. They report feeling guilty about not being able to do more or to do enough to save lives. As one nurse writes,

> Nurses frequently hold themselves responsible for the death of patients. They feel guilty about not knowing enough, not being good enough, and not being efficient. They believe that they should have been able to overcome the adversities and performed superhuman deeds.

This kind of magical thinking led some to have feelings of failure, which they attributed not to external circumstances, but to their own lack of self-worth. Thus they assumed extraordinary responsibility for those whom, despite their best efforts, died. This survivor guilt manifested itself in feelings of unworthiness and depression.

Frances Shea writes:

> When my tour was up and I returned stateside, I have to tell you that I felt guilty - guilty that I didn't do enough, didn't care enough, guilty that I left my shipmates and patients behind. This was not an unusual reaction. Many of us experienced similar feelings.

Women who served in Vietnam experienced yet another stress, that of being women in a male-dominated environment. Many were objects of sexual harrassment. Many became substitute mothers, wives, lovers, and sisters.

One nurse reports that even the chaplain sought out the nurse with his problems. Some nurses were treated like "tokens" or "temps" or "Kelly girls."

Harrassment was so bad in some places that one nurse interviewed reported that the barb wire around her treatment station was more to protect the nurses from friendly soldiers than from the enemy.

Just as there were hardships to be endured, there were successes to be celebrated. E. A. Paul and J. S. O'Neill list these positive aspects:

- a more positive attitude toward their nursing competence
- greater tolerance
- more holistic attitude toward life
- an increase in positive attitudes which included empathy, sympathy, and respect for having endured and survived.

Anne Samson and Sally Butler report that many Vietnam era veterans report: "pride in serving their country; having endured and triumphed over adversity, increased confidence to function as a necessary part of a support team; new-found inner strength; and an increased level of tolerance and endurance."

Many veterans highlight their personal and professional growth. They celebrate the tremendous feeling of being on a team. They cherish having been permitted to provide medical treatment which is provided in civilian life only by other specialties.

Chaplains surveyed who served hospitals in Vietnam support these observations from other writings. They listed fatigue, overwork, excessive casualties, stress, grief, overexposure to the wounded, personal problems, and spiritual concerns as among medical staff needs for pastoral care.

Stresses noted were: disregard, insensitivity, repetitiveness of torn bodies, loneliness, insensitive administrators, rage, sense of futility, and inappropriate "intimate" relationships among staff.

These hospital chaplains noted coping mechanisms which included: religious activities, athletic and social activities, crying, drinking heavily, jokes and twisted humor, withdrawal, talking with the chaplain, playing poker, cursing the system, promiscuity, busyness, and caring for children at orphanages.

Only one chaplain reported an incident that involved ethics. The rest did not think it was a problem. Some did report addressing morality issues. One reported staff needing the chaplain to symbolize the moral and ethical conscience involved in healing ministry.

Anne Samson and Sally Butler write that nurses lacked training concerning the moral and ethical implications of triage decisions. One chaplain noted that for all staff members triage was a painful, but necessary procedure. Another said that triage didn't always work to save lives.

Triage challenged both moral and ethical rules that medical treatment personnel had been taught to live by. Often these had to be replaced by the second best "situational" ethics of war-time behavior.

The Unit Ministry Team's function is to be there not just for soldiers who are casualties, but also for the staff caring for them. Sometimes the UMT only provides a ministry of sustaining. The situation is what is not going to change very much, or at least not in the near future. So the UMT listens, supports, and stands by those who must make life and death decisions and care for the mutilated and dying soldier.

At other times, the UMT provides a crisis and stress ministry, teaching stress management, making suggestions as to how one can cope with the horrors of one's experiences, and assisting staff to develop world views, belief systems, perspectives, values, and meanings that will be supportive to them as they provide medical care.

UMTs can provide those who are grieving opportunities for catharsis, sharing of their thoughts and feelings, and reassurances that life goes on.

UMTs can provide those feeling guilty assurances of God's understanding and forgiveness and of the community's acceptance. They can affirm personal worth. They can challenge extraordinary senses of responsibility for others as being unrealistic. They can assure departing staff that patients will be cared for, and that there are others to take their place. They can offer sacraments which are signs of God's forgiveness.

UMTs can provide a ministry of guiding to those struggling with their own values and behavior, to those who are growing in faith and perspectives, to those developing world views and belief systems that are more mature and supportive. They can affirm inner resources for coping and growth and provide external insights and perspectives.

UMTs can offer services of worship, times for reflection and study of sacred writings, and opportunities for supportive fellowship within a religious context.

Lastly, UMTs can celebrate with staff their successes, their hopes and dreams, their victories, and finally the war's end or their returning home.

Each of these ministries assumes that UMTs and staff will have developed trusting relationships. Since it is often difficult for medical staff to grasp the nature of the UMT's work, it is important for acceptance that UMTs make their roles very clear.

UMTs must "stake their claim" for their kind of caring for patients and work out with staff how each profession's work complements the other. UMTs must establish working alliances and be members of the healing team. Hospital chaplains surveyed reported that all were accepted, but for some it took time before they were given consults by physicians and other staff.

MINISTRY TO RETURN TO DUTY CASUALTIES

Medical casualties who are treated and then return to duty are the greatest source of replacements on the AirLand battlefield. As many as 66% of all medical casualties will be treated and returned to duty in Echelons I and II.

TAA 93 projects that approximately 31% of the casualties admitted to Echelon III medical treatment facilities or 35,582 soldiers and approximately 55% of the direct admissions to Echelon IV hospitals or 5,167 soldiers will be returned to duty within 30 days following medical treatment.

Soldiers returning to duty in Echelons I and II receive religious support from Unit Ministry Teams organic to maneuver units within division areas of operations. Soldiers returning to duty from Echelons III and IV receive religious support from Unit Ministry Teams organic to medical units and other augmenting UMTs located within the corps.

Returning to duty category casualties will have experienced the sacrifices of battle in varying degrees. They may be experiencing crises of faith, grief, guilt, fear, or despair. Crisis and stress ministry is the most appropriate ministry to provide. Ministry of guiding, sacramental ministry, and ministry of worship are also supportive. These ministries can be provided as previously described.

Casualties who are returning to duty require more than simplistic reassurances that they will survive, which cannot be known. Unit Ministry Teams are more than "cheerleaders" who offer support and encouragement.

It is not the task of the UMT to "save" or "rescue" battle scarred soldiers from returning to battle, even though they may empathize or even sympathize with soldiers not wanting to return to duty.

Becoming involved in decision making as to who returns to duty is not recommended, even though UMTs may provide data concerning casualties' feelings, attitudes, or abilities to function effectively. Who returns to duty is a medical decision. Which battle fatigue casualties return to duty and when are also medical decisions.

UMTs can be supportive both to returning casualties and to medical treatment personnel making these decisions particularly when moral, ethical, and societal value factors are involved.

One of the greatest motivating values for returning to duty is commitment. Commitment may be to buddies, to self, or to some moral value. Organizational commitment is greatest when the goals, purposes, and norms of a particular group coincide with personal beliefs, perceptions, and values. Organizational commitment is supported by unit cohesion and esprit.

Cohesion is the bonding together of soldiers in a way which sustains their will and commitment to each other, the unit, and mission accomplishment despite combat stress. It is a feeling of belonging to a team who accepts the unit's

mission as its mission. Members of the team feel responsible for one another. They are attracted to the team, want to be part of the team and receive satisfaction as a member of the team.

Good interpersonal relationships, good leadership, open communication and candor, living, working, and playing together over an extended period, and having a common enemy all support unit cohesion. Relationships are built upon shared experiences, mutual affection, interdependence, trust, and loyalty. Cohesion increases as the number of roles and settings in which members know one another increases.

The fact that some returning nurses felt guilty about leaving others behind to care for casualties is an indication of their high level of commitment to others.

Returning soldiers to duty to the same units from which they came for medical treatment enhances their effectiveness upon return. Facilitating contact with the unit during the time of medical treatment helps maintain unit cohesion. Taking care of team members with the good of the unit in mind strengthens morale.

Esprit is unity of purpose and devotion to a cause that is shared by a collection of primary groups which may not be coextensive in their membership, but linked to one another by members who occupy positions in more than one group. Members of these groups may or may not know personally members of other primary groups.

Commitment to self is related to personal and professional goals, values, meanings, and desired successes. It may or may not be related to team commitment, although ideally personal and professional success coincides with team successes or the accomplishment of group goals.

Commitment to moral values is related to basic moral codes, world views, cultural and societal values and meanings, and belief systems. For an example, soldiers may be committed to establishing a moral universe of values and meanings which they may identify as the Kingdom of God. They may commit themselves to fighting and even dying for freedom, for the right of others to determine their own forms of government, or the right of others to live and work where they want.

Morale is a psychological state of mind characterized by a sense of well-being based upon confidence in self and primary groups.

Unit Ministry Teams may become involved in supporting policies which support commitment, cohesion, esprit, or morale. According to AR 165-20, paragraph 2-2, b (1), one of their duties is to advise the commander and staff on matters of morale as affected by religion. They can best support returning soldiers by not only providing ministry, but also by being aware of these factors.

MINISTRY OF THE LAITY

As larger units to which UMTs are assigned are deployed into widely-dispersed smaller units during military operations, UMTs may not be where religious support to casualties is most required on the AirLand battlefield. UMTs are not usually at points of wounding.

A battalion's UMT may be restricted to providing religious support at only one of two casualty treatment locations within a battalion's area of operations. UMTs cannot provide religious coverage at all the projected casualty collection and holding areas or ambulance exchange points at which casualties may be.

The requirement for religious support will exceed religious coverage capacities to provide religious support, particularly in mid-high intensity conflicts. Even in low intensity conflicts, UMTs may not be initially deployed with small combat units.

Lay persons throughout human and religious history have almost continually been involved in ministry to the dying, crisis and stress ministry, and the ministries of sustaining, guiding, and worship. Lay persons have visited, comforted, and proclaimed God's healing presence to the sick and the disabled. They have encouraged and supported those who are suffering in times of anxiety, suffering, and loss.

Lay persons have provided spiritual counseling, teaching, and guidance. They have even heard confessions, helped others reconcile with others and God, and authoritatively and effectively proclaimed forgiveness. They have stood by those in need and helped restore relationships to wholeness. As they have been educated and supervised in providing ministry, their contribution has been even greater.

One of the primary ministries provided by lay persons has been the ministry of sustaining, that is, being with those who are suffering.

The Roman philosopher Cicero, when his daughter died in 45 B.C., developed a model for comforting others. Jonathon being with David (I Samuel 20:41) and Ruth staying with her mother-in-law are two Biblical examples. The Apostle Paul frequently exhorts early Christians to "bear one another's burdens, and so fulfill the law of Christ" (Galatians 6:2).

Even as distinctions between laity and clergy developed during the Middle Ages and the Reformation, lay persons provided pastoral care ministries. Martin Luther, Martin Bucer, Jakob Spener, John Calvin, and John Wesley all supported lay involvement in providing ministry.

Many contemporary programs have developed which train and supervise lay persons to provide pastoral care. Theologically, pastoral care is the work and the responsibility of the whole people of God.

Dietrich Bonhoeffer in Life Together, citing how Jesus has borne our griefs, exhorts every Christian to join in a "ministry of bearing." Henri

Nouwen, a contemporary Catholic theologian encourages all persons to enter into "solidarity" with those who are suffering.

Soldiers staying with wounded and dying buddies often at great risk to themselves and personal sacrifice testifies that they are already providing this ministry.

General S. L. A. Marshall once said that the presence of a buddy is what keeps an infantry soldier moving forward. It is often the presence of a buddy that sustains a wounded casualty until medical treatment arrives or the casualty is evacuated. This is ministry.

Buddies and combat medics are often the last persons dying soldiers see. Dying soldiers may request that they write to their families, send home their personal effects, baptize them, hear their confessions, or simply stay with them until they die.

Combat soldiers and medics may assure them of God's love, that God will take care of their families, and even forgive them. One combat medic reported that he always asked dying soldiers if they believed in God. What was surprising to him was that every soldier who "died in his arms" said that he did.

Buddy aid and combat lifesaving, together with religious support to casualties provided by buddies, strengthens a unit's cohesion and helps stabilize and sustain soldiers until they can be treated or evacuated.

UNIT MINISTRY TEAMS AS CASUALTIES

Unit Ministry Teams are vulnerable on the AirLand battlefield to becoming combat casualties themselves. They may suffer wounds, injuries, disease, battle fatigue, or even death. In efforts to be all things to all people, they may "burn out" or become exhausted.

UMTs may suffer from crises of faith, grief, guilt, fear, or despair. They themselves may require religious support from coworkers, other UMTs, chaplain supervisors, or commanders.

Because Unit Ministry Teams will be "where the action is," they will experience risks, sacrifices, hardships, and feelings similar to the soldiers they serve. They will provide some religious support to themselves, members of the UMT to each other.

UMTs will need to maintain a clear spiritual focus firmly rooted in religious tradition. They will need to affirm their own inner resources for coping with the horrors of their experience. They will also need to affirm spiritual resources. Their own belief systems, world views, interpretations, values, and meanings will be challenged, each of which may be pushed to its limits. They may be unprepared for what they will experience.

First and foremost, in order to provide religious support to soldiers, Unit Ministry Teams must survive the battle without becoming casualties themselves. They will need to understand the battlefield in all its phases and complexities. They will need to be proficient in common soldier skills, such as: communication, navigation, cover and concealment, escape and evasion, and NBC survival. They must apply tactical considerations in all their actions.

In January, 1985, Chaplain James White noted that UMTs receiving training at the National Training Center, Fort Irwin, CA, were frequent casualties. Many UMTs were not practicing good tactical sense and wandered around the battlefield visiting their troops. Consequently, many were "killed by the enemy."

In August, 1985, Chaplain Mike Yunk, 5th Infantry Division Chaplain, restricted independent movements on the battlefield by the division's UMTs. Maneuver UMTs were still "killed," as opposition forces attacked the combat trains, but primarily at battalion aid stations.

In February, 1986, Chaplain White recommended that UMTs move with units and soldiers:

1) who have night vision devices, since most movements are at night
2) who have hardened vehicles
3) who move in convoys
4) who move back and forth and not laterally among units

UMTs also need to know their unit's tactics and mission. Unit Ministry Teams not using their time in the field to "train up" with their units in battle and survival skills represents a serious deficiency.

UMTs will not be able to survive AirLand battles if they continue to conduct their ministries as they presently do during peacetime field exercises. As Chaplain Sanford, a 5th Infantry Division brigade chaplain has said, "They don't need to work harder, but smarter."

When chaplains or chaplain assistants do become casualties, supervising UMTs will need to requisition replacements or provide replacements from their own assets to provide continuing religious coverage. One possibility is to use augmenting reserve UMTs assigned to the division. Supervising UMTs also have a special responsibility to visit and provide ministry for UMTs who become casualties.

One of the functions of the brigade chaplain is to provide area coverage support to task force ministry teams, "situation permitting, without waiting for exhausted, even dazed subordinates to request it" (FM 16-5). Crisis and stress ministry is provided to these teams in addition to augmenting religious coverage.

Chaplains assigned to hospitals in Vietnam reported that they required periodic support in order to "get away" for a day off, a day of recollection,

or some rest and recuperation (R & R). Those chaplains serving alone in their particular hospital reported the greatest need for such augmentation.

Undoubtedly, UMTs will become casualties. During World War II, 77 chaplains were killed in combat. In Korea, 10 chaplains were killed, several while caring for the wounded. In Vietnam, 15 chaplains died. Countless others were wounded or injured. Unknown is the number of emotional and psychological disabilities. Many refuse to talk about their experience, perhaps accounting for the low rate of replies from hospital chaplains sent questionaires concerning their ministry in Vietnam.

SUMMARY

Religious support to casualties is multi-faceted. Chaplains and chaplain assistants provide this support to all soldiers on the battlefield. It addresses five spiritual conditions: crisis of faith, grief, guilt, fear, and despair.

It comprises eight distinguishable yet interrelated and overlapping ministries: ministry of presence, ministry to the dying, ministry of sustaining, sacramental ministry, crisis and stress ministry, ministry of guiding, ministry of worship, and ministry of celebration.

UMTs provide these ministries from the FLOT throughout the battlefield and in all five NATO echelons of medical treatment. Each ministry is related to specific patient conditions which provide a basis for manpower authorizations and staffing.

The primary deficiencies identified are the lack of Unit Ministry Teams trained in trauma ministry, the lack of religious coverage for holding areas, and the lack of planning for mass casualty situations.

Casualties who receive religious support heal better and faster than those who do not. They are also more easily stabilized for evacuation. Religious support strengthens and encourages casualties who are returning to duty. They are better able to survive the battle.

Religious support is essential if the strength of combat soldiers is to be conserved and casualties are to receive the best possible support and care on the battlefield.

APPENDIX H

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19. ABSTRACT (Continue on reverse if necessary and identify by block number)

"Unit Ministry Team Religious Support to Casualties on the AirLand Battlefield" is a study of chaplains' and chaplain assistants' roles, functions, tasks, and capabilities in providing religious support to casualties on the AirLand battlefield.

The study was designed to define Unit Ministry Team ministry to casualties, assess Unit Ministry Team support in doctrine and training, determine the scope of Unit Ministry Team support requirements, identify Unit Ministry Team capabilities, evaluate the role and the function of the chaplain assistant in religious support to casualties, and identify changes required in doctrine, organization, operational concepts, and training to correct deficiencies.

Findings are based on an extensive search of civilian and military literature which references religious support provided to casualties, upon responses to questionnaires sent to division chaplains and chaplains assigned to hospitals in Vietnam, and upon insights provided by a Subject Matter Expert Panel. (continued)

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BLOCK 18 (continued) ministry, spiritual conditions, crisis, faith, fear, guilt, grief, despair, battle fatigue, medical treatment personnel, combat stress control, mass casualty, evacuation, HSSALB, ALB, Vietnam, Combat Stress, THREAT.

BLOCK 19 (continued) Analysis identified five spiritual conditions which Unit Ministry Teams address in eight different, yet overlapping and interrelated, ministeries. The spiritual conditions are: crisis of faith, fear, grief, guilt, and despair. The ministeries are: ministry of presence, ministry to the dying, crisis and stress ministry, sacramental ministry, ministry of sustaining, ministry of guiding, ministry of worship, and ministry of celebration.

Deficiencies include: lack of capabilities to locate and move to casualty treatment locations, inadequate abilities to provide coordinated ministry in mass casualty situations, inadequate ability to function in contaminated environments, lack of manpower requirement criteria for assigning Unit Ministry Teams to medical treatment facilities, and inadequate ability to provide distinctive religious group ministrations.

The study notes how neither chaplain branch nor health service support doctrine adequately describes Unit Ministry Team religious support to casualties.

The study recommends changes in doctrine, training, organization, and policy to correct these deficiencies. It also recommends separate studies to correct deficiencies in providing religious support in contaminated environments and in providing distinctive faith group ministrations.

The study emphasizes spiritual, theological, ethical, and psychological preparedness for combat ministry to casualties as essential to providing adequate religious support to casualties on the AirLand battlefield.